

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: 14-0239	Period: From 07/01/2019 To 06/30/2020	Worksheet S Parts I-III Date/Time Prepared: 4/22/2021 7:56 am
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 4/22/2021	Time: 7:56 am
	2. ☐ Manually prepared cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☐ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by JAVON BEA HOSPITAL (14-0239) for the cost reporting period beginning 07/01/2019 and ending 06/30/2020 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.

(Signed)

Officer or Administrator of Provider(s)

Title

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	3,328,625	657,120	0	0	1.00
2.00	Subprovider - IPF	0	4,147	592		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
200.00	Total	0	3,332,772	657,712	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA					Provider CCN: 14-0239		Period: From 07/01/2019 To 06/30/2020		Worksheet S-2 Part I Date/Time Prepared: 4/22/2021 7:56 am		
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 2400 N ROCKTON AVENUE			PO Box:				1.00			
2.00	City: ROCKFORD			State: IL		Zip Code: 61103		County: WINNEBAGO			
		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			JAVON BEA HOSPITAL	140239	40420	1	07/01/1966	N	P	O
4.00	Subprovider - IPF			PSYCHIATRIC UNIT	14S239	40420	4	03/01/1990	N	P	O
5.00	Subprovider - IRF										
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										
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										
17.20	Hospital-Based (OPT) I										
17.30	Hospital-Based (OOT) I										
17.40	Hospital-Based (OSP) I										
18.00	Renal Dialysis										
19.00	Other										
							From:		To:		
							1.00		2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)						07/01/2019		06/30/2020		
21.00	Type of Control (see instructions)						2				
							1.00		2.00		
							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				
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	Y				
22.02	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				
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N			
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.					3	N				

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Part I
Date/Time Prepared:
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0239

Period:
From 07/01/2019
To 06/30/2020Worksheet S-2
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		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	
60.02	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		23.01	1	60.02	
60.03	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		23.02	1	60.03	
		Y/N	IME	Direct GME	IME	Direct GME
		1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)					61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)					61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)					61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).					61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)					61.05
61.06	Enter the amount of ACA \$5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)					61.06
		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.20
					1.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)				0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings						
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)				N	63.00

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

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

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				V	XIX		
				1.00	2.00		
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			N			108.00
				Physical	Occupational	Speech	Respiratory
				1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.			N	N	N	109.00
						1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.			N			110.00
				1.00	2.00		
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.			N			111.00
				1.00	2.00	3.00	
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.			N			112.00
Miscellaneous Cost Reporting Information							
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.			N			0115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.			N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.			Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.			2			118.00
				Premiums	Losses	Insurance	
				1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:			2,963,077	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 §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.			N		N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.			Y			121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.			N			122.00
Transplant Center Information							
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.			N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						130.00

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			1.00		2.00			
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.							132.00
133.00	Removed and reserved							133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.							134.00
All Providers								
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)						Y	HB0764
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: MERCY ROCKFORD HEALTH SYSTEM		Contractor's Name: NGS		Contractor's Number: 00450		141.00	
142.00	Street: 2400 NORTH ROCKTON AVENUE		PO Box:				142.00	
143.00	City: ROCKFORD		State: IL		Zip Code: 61103		143.00	
			1.00					
144.00	Are provider based physicians' costs included in worksheet A?						Y	144.00
			1.00			2.00		
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.						Y	N
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.						N	
			1.00					
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.						N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.						N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.						N	149.00
			Part A		Part B		Title V	
			1.00		2.00		3.00	
			Title XIX		4.00			
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)								
155.00	Hospital		N	N	N	N	N	155.00
156.00	Subprovider - IPF		N	N	N	N	N	156.00
157.00	Subprovider - IRF		N	N	N	N	N	157.00
158.00	SUBPROVIDER							158.00
159.00	SNF		N	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY		N	N	N	N	N	160.00
161.00	CMHC			N	N	N	N	161.00
161.10	CORF			N	N	N	N	161.10
161.20	OUTPATIENT PHYSICAL THERAPY			N	N	N	N	161.20
161.30	OUTPATIENT OCCUPATIONAL THERAPY			N	N	N	N	161.30
161.40	OUTPATIENT SPEECH PATHOLOGY			N	N	N	N	161.40
			1.00					
Multicampus								
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.						N	165.00
			Name		County		State	
			0		1.00		2.00	
			3.00		4.00		5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	
			1.00					
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act								
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.						Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)							168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)							168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						9.99	169.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0239	Period: From 07/01/2019 To 06/30/2020	Worksheet S-2 Part I Date/Time Prepared: 4/22/2021 7:56 am
			Beginning 1.00	Ending 2.00
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
			1.00	2.00
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N		0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0239	Period: From 07/01/2019 To 06/30/2020	Worksheet S-2 Part II Date/Time Prepared: 4/22/2021 7:56 am
			Y/N 1.00	Date 2.00
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y		3.00
		Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	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 cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	Y		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N 1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N	14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		Y	15.00
		Part A		Part B
		Y/N 1.00	Date 2.00	Y/N 3.00
				Date 4.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	10/21/2020	Y
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0239

Period:
From 07/01/2019
To 06/30/2020Worksheet S-2
Part II
Date/Time Prepared:
4/22/2021 7:56 am

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?				36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	AMY	SEACRIST		41.00
42.00	Enter the employer/company name of the cost report preparer.	MERCY HEALTH SYSTEM			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	815-971-5010	ASEACRIST@MHMAIL.ORG		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0239

Period:
From 07/01/2019
To 06/30/2020Worksheet S-2
Part II
Date/Time Prepared:
4/22/2021 7:56 am

		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DIRECTOR OF REIMBURSEMENT	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: 14-0239

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part I
Date/Time Prepared:
4/22/2021 7:56 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	216	77,116	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)		216	77,116	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	29	8,689	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
11.01 NEONATAL INTENSIVE CARE	34.01	52	19,032	0.00	0	11.01
11.02 PEDIATRIC INTENSIVE CARE	34.02	8	2,688	0.00	0	11.02
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		305	107,525	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	6	4,396		0	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	99.10				0	25.10
25.20 CMHC - OUTPATIENT PHYSICAL THERAPY	99.20				0	25.20
25.30 CMHC - OUTPATIENT OCCUPATIONAL THERAPY	99.30				0	25.30
25.40 CMHC - OUTPATIENT SPEECH PATHOLOGY	99.40				0	25.40
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		311				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)		10	4,380			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: 14-0239

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part I
Date/Time Prepared:
4/22/2021 7:56 am

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	13,390	4,269	41,307			1.00
2.00	HMO and other (see instructions)	9,337	18,187				2.00
3.00	HMO IPF Subprovider	238	752				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	13,390	4,269	41,307			7.00
8.00	INTENSIVE CARE UNIT	2,476	70	5,876			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
11.01	NEONATAL INTENSIVE CARE	0	3,140	13,823			11.01
11.02	PEDIATRIC INTENSIVE CARE	0	222	1,091			11.02
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		1,182	3,696			13.00
14.00	Total (see instructions)	15,866	8,883	65,793	24.75	1,749.01	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	475	162	2,728	0.00	21.86	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			210			24.10
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	0	0	0	0.00	0.00	25.10
25.20	CMHC - OUTPATIENT PHYSICAL THERAPY	0	0	0	0.00	0.00	25.20
25.30	CMHC - OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0.00	0.00	25.30
25.40	CMHC - OUTPATIENT SPEECH PATHOLOGY	0	0	0	0.00	0.00	25.40
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				24.75	1,770.87	27.00
28.00	Observation Bed Days		0	8,396			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	448	2,749			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: 14-0239

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part I
Date/Time Prepared:
4/22/2021 7:56 am

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	3,236	1,069	12,383	1.00
2.00 HMO and other (see instructions)			1,671	3,142		2.00
3.00 HMO IPF Subprovider				189		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
11.01 NEONATAL INTENSIVE CARE						11.01
11.02 PEDIATRIC INTENSIVE CARE						11.02
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	3,236	1,069	12,383	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	77	28	559	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	0.00					25.10
25.20 CMHC - OUTPATIENT PHYSICAL THERAPY	0.00					25.20
25.30 CMHC - OUTPATIENT OCCUPATIONAL THERAPY	0.00					25.30
25.40 CMHC - OUTPATIENT SPEECH PATHOLOGY	0.00					25.40
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0239

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part II
Date/Time Prepared:
4/22/2021 7:56 am

	Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	116,207,063	0	116,207,063	3,683,401.90	31.55
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		72,396	0	72,396	931.00	77.76
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non Physician-Part B		59,879	0	59,879	614.00	97.52
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	1,506,090	1,506,090	52,137.17	28.89
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)		3,821,916	384,755	4,206,671	122,246.94	34.41
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		3,100,754	0	3,100,754	36,523.86	84.90
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		160,247	0	160,247	1,655.50	96.80
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		24,303,309	0	24,303,309	511,603.00	47.50
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)		24,796,851	0	24,796,851		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		891,359	0	891,359		
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		11,325	0	11,325		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		8,805	0	8,805		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		353,615	0	353,615		
25.50	Home office wage-related (core)		3,527,909	0	3,527,909		
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: 14-0239

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part II
Date/Time Prepared:
4/22/2021 7:56 am

		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	5,594	0	5,594	128.00	43.70	26.00
27.00	Administrative & General	5.00	10,540,894	-9,252,649	1,288,245	126,362.43	10.19	27.00
28.00	Administrative & General under contract (see inst.)		1,002,300	0	1,002,300	4,592.99	218.22	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,485,925	335,496	1,821,421	63,742.52	28.57	30.00
31.00	Laundry & Linen Service	8.00	148,872	88,464	237,336	11,736.38	20.22	31.00
32.00	Housekeeping	9.00	3,164,454	58,976	3,223,430	216,675.92	14.88	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	2,539,487	-1,585,029	954,458	55,171.65	17.30	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	1,710,302	1,710,302	109,484.78	15.62	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	3,636,819	208,003	3,844,822	104,968.15	36.63	38.00
39.00	Central Services and Supply	14.00	1,667,550	216,890	1,884,440	96,233.43	19.58	39.00
40.00	Pharmacy	15.00	4,536,409	375,769	4,912,178	108,532.86	45.26	40.00
41.00	Medical Records & Medical Records Library	16.00	1,186,552	0	1,186,552	39,232.00	30.24	41.00
42.00	Social Service	17.00	198,978	26,262	225,240	8,418.57	26.76	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0239

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part III
Date/Time Prepared:
4/22/2021 7:56 am

	Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	117,149,484	-1,506,090	115,643,394	3,635,243.72	31.81	1.00
2.00	Excluded area salaries (see instructions)	3,821,916	384,755	4,206,671	122,246.94	34.41	2.00
3.00	Subtotal salaries (line 1 minus line 2)	113,327,568	-1,890,845	111,436,723	3,512,996.78	31.72	3.00
4.00	Subtotal other wages & related costs (see inst.)	27,564,310	0	27,564,310	549,782.36	50.14	4.00
5.00	Subtotal wage-related costs (see inst.)	28,336,085	0	28,336,085	0.00	25.43	5.00
6.00	Total (sum of lines 3 thru 5)	169,227,963	-1,890,845	167,337,118	4,062,779.14	41.19	6.00
7.00	Total overhead cost (see instructions)	30,113,834	-7,817,516	22,296,318	945,279.68	23.59	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 14-0239

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part IV
Date/Time Prepared:
4/22/2021 7:56 am

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	4,733,889	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	372	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)	10,888,276	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	358,245	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	77,592	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)	617,187	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	0	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	493,915	16.00
TAXES			
17.00	FICA-Employers Portion Only	7,367,559	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	975,116	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	549,804	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	26,061,955	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COST		25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 14-0239

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part V
Date/Time Prepared:
4/22/2021 7:56 am

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	3,100,754	26,061,955	1.00
2.00	Hospital	3,100,754	25,964,075	2.00
3.00	Subprovider - IPF	0	97,880	3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
16.10	Hospital-Based-CMHC 10	0	0	16.10
16.20	Hospital-Based-CMHC 20	0	0	16.20
16.30	Hospital-Based-CMHC 30	0	0	16.30
16.40	Hospital-Based-CMHC 40	0	0	16.40
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 14-0239

Period:
From 07/01/2019
To 06/30/2020

Worksheet S-10

Date/Time Prepared:
4/22/2021 7:56 am

				1.00	
	Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.195531	1.00
	Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid			117,271,652	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?			Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?			N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid			23,618,462	5.00
6.00	Medicaid charges			424,009,507	6.00
7.00	Medicaid cost (line 1 times line 6)			82,907,003	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)			0	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP			0	9.00
10.00	Stand-alone CHIP charges			0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)			0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)			0	12.00
	Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)			0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)			0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)			0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)			0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care			0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations			0	18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)			0	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)	11,274,338	2,231,943	13,506,281	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	2,204,483	2,231,943	4,436,426	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	2,204,483	2,231,943	4,436,426	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)			23,122,879	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			1,441,305	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			2,217,391	27.01
28.00	Non-Medicare bad debt expense (see instructions)			20,905,488	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			4,863,757	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			9,300,183	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			9,300,183	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0239

Period:
From 07/01/2019
To 06/30/2020

Worksheet A

Date/Time Prepared:
4/22/2021 7:56 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		0	0	350,000	350,000	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	32,785,551	32,785,551	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	5,594	19,412,855	19,418,449	0	19,418,449	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	10,540,894	136,438,678	146,979,572	-43,227,887	103,751,685	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	1,485,925	6,670,441	8,156,366	335,496	8,491,862	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	148,872	5,452	154,324	88,464	242,788	8.00
9.00	00900	HOUSEKEEPING	3,164,454	1,331,034	4,495,488	58,976	4,554,464	9.00
10.00	01000	DIETARY	2,539,487	1,707,738	4,247,225	-2,735,162	1,512,063	10.00
11.00	01100	CAFETERIA	0	0	0	2,860,435	2,860,435	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	3,636,819	461,897	4,098,716	208,003	4,306,719	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,667,550	1,094,742	2,762,292	152,035	2,914,327	14.00
15.00	01500	PHARMACY	4,536,409	26,499,649	31,036,058	-24,121,504	6,914,554	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,186,552	460,932	1,647,484	0	1,647,484	16.00
17.00	01700	SOCIAL SERVICE	198,978	20,902	219,880	26,262	246,142	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	1,506,090	1,506,090	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	3,688,611	3,688,611	22.00
23.00	02300	PARAMDICAL ED PROGRAM XRAY	263,294	43,289	306,583	0	306,583	23.00
23.01	02301	PASTORAL EDUCATION PROGRAM	0	0	0	155,626	155,626	23.01
23.02	02302	PARAMED EDUC EMT PROGRAM	495,986	388,982	884,968	103,900	988,868	23.02
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	23,656,044	5,429,902	29,085,946	-3,705,998	25,379,948	30.00
31.00	03100	INTENSIVE CARE UNIT	4,873,163	1,614,643	6,487,806	-679,419	5,808,387	31.00
34.01	03401	NEONATAL INTENSIVE CARE	8,864,904	2,035,239	10,900,143	-1,611,120	9,289,023	34.01
34.02	03402	PEDIATRIC INTENSIVE CARE	928,936	321,470	1,250,406	-33,299	1,217,107	34.02
40.00	04000	SUBPROVIDER - IPF	1,291,214	138,412	1,429,626	113,779	1,543,405	40.00
43.00	04300	NURSERY	0	0	0	3,521,811	3,521,811	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	8,283,651	20,508,929	28,792,580	-14,203,833	14,588,747	50.00
51.00	05100	RECOVERY ROOM	1,138,182	144,051	1,282,233	25,141	1,307,374	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,074,907	3,196,624	7,271,531	-554,143	6,717,388	52.00
53.00	05300	ANESTHESIOLOGY	546,518	2,477,502	3,024,020	-578,697	2,445,323	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,296,287	10,868,212	16,164,499	-8,848,754	7,315,745	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	955,826	812,416	1,768,242	-41,831	1,726,411	55.00
56.00	05600	RADIOISOTOPE	241,411	827,542	1,068,953	-470,017	598,936	56.00
57.00	05700	CT SCAN	1,185,232	816,064	2,001,296	-299,959	1,701,337	57.00
58.00	05800	MRI	778,402	240,438	1,018,840	0	1,018,840	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	4,300,489	11,075,860	15,376,349	192,634	15,568,983	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	366,593	69,557	436,150	51,459	487,609	64.00
65.00	06500	RESPIRATORY THERAPY	2,676,165	1,699,295	4,375,460	-463,181	3,912,279	65.00
66.00	06600	PHYSICAL THERAPY	1,899,099	227,664	2,126,763	519	2,127,282	66.00
69.00	06900	ELECTROCARDIOLOGY	1,559,984	585,326	2,145,310	-79,804	2,065,506	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	610,842	254,465	865,307	67,511	932,818	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	20,745,186	20,745,186	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	11,827,899	11,827,899	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	24,497,273	24,497,273	73.00
73.01	07301	INJECTABLE DRUGS	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	840,050	840,050	8,043	848,093	74.00
76.00	03340	GI LAB	813,233	1,213,943	2,027,176	-737,706	1,289,470	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09003	PAIN CENTER	632,273	260,073	892,346	-132,912	759,434	90.01
90.02	09001	ANTENATAL TEST CENTER	742,546	162,004	904,550	0	904,550	90.02
90.03	09002	CHILD PSYCHIATRIC CLINIC	141,134	15,797	156,931	0	156,931	90.03
90.04	09004	SPECIAL SURGICAL SERVICES	320,179	196,813	516,992	-78,898	438,094	90.04
90.05	09005	GENETIC SERVICES	302,478	30,858	333,336	0	333,336	90.05
90.06	09006	HBP	0	0	0	0	0	90.06
90.07	09007	MAIN	0	0	0	0	0	90.07
90.08	09008	RMB	0	0	0	0	0	90.08
90.09	09009	MULFORD	0	0	0	0	0	90.09
90.10	09010	ALPINE	0	0	0	0	0	90.10

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0239

Period:
From 07/01/2019
To 06/30/2020

Worksheet A

Date/Time Prepared:
4/22/2021 7:56 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
90.11	09011	ROSCOE	0	0	0	0	0	90.11
90.12	09012	BYRON	0	0	0	0	0	90.12
90.13	09013	WINNEBAGO	0	0	0	0	0	90.13
90.14	09014	PERRYVILLE	0	0	0	0	0	90.14
90.15	09015	BELVIDERE	0	0	0	0	0	90.15
90.16	09016	SPRINGBROOK	0	0	0	0	0	90.16
90.17	09017	MCFARLAND	0	0	0	0	0	90.17
90.18	09018	CHERRYVALLEY	0	0	0	0	0	90.18
90.19	09019	KLECKNER	0	0	0	0	0	90.19
90.20	09020	GALLERIA	0	0	0	0	0	90.20
90.21	09021	RIVERSIDE MOB	0	0	0	0	0	90.21
90.22	09022	MULFORD-LENOX	0	0	0	0	0	90.22
91.00	09100	EMERGENCY	8,085,135	3,149,288	11,234,423	-815,883	10,418,540	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92.00
95.00	09500	AMBULANCE SERVICES	995,577	852,601	1,848,178	13,803	1,861,981	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	115,431,218	264,601,629	380,032,847	-35,500	379,997,347	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.01	19301	BELOIT HEART STANDBY	37,010	2,060	39,070	0	39,070	193.01
194.00	07950	GUEST CENTER	13,323	254,834	268,157	0	268,157	194.00
194.01	07954	OTHER NONREIMBURSEABLE COST CENTER	18,186	25,102	43,288	0	43,288	194.01
194.02	07951	COMMUNITY SERVICES	143,217	743,516	886,733	0	886,733	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERSO	0	0	0	0	0	194.03
194.04	07952	AUXILIARY	62,039	265,515	327,554	35,500	363,054	194.04
194.05	07956	RETAIL PHARMACY	502,070	2,452,282	2,954,352	0	2,954,352	194.05
194.08	07955	DIALYSIS RENTED SPACE	0	0	0	0	0	194.08
200.00		TOTAL (SUM OF LINES 118 through 199)	116,207,063	268,344,938	384,552,001	0	384,552,001	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0239

Period:
From 07/01/2019
To 06/30/2020

Worksheet A

Date/Time Prepared:
4/22/2021 7:56 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	350,000	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	32,785,551	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,560,881	21,979,330	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-81,845,669	21,906,016	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	8,491,862	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	242,788	8.00
9.00	00900	HOUSEKEEPING	0	4,554,464	9.00
10.00	01000	DIETARY	0	1,512,063	10.00
11.00	01100	CAFETERIA	-2,035,502	824,933	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	4,306,719	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	720,402	3,634,729	14.00
15.00	01500	PHARMACY	438,558	7,353,112	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,511,028	4,158,512	16.00
17.00	01700	SOCIAL SERVICE	-2,174	243,968	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	1,506,090	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	3,688,611	22.00
23.00	02300	PARAMDICAL ED PROGRAM XRAY	-65,206	241,377	23.00
23.01	02301	PASTORAL EDUCATION PROGRAM	0	155,626	23.01
23.02	02302	PARAMED EDUC EMT PROGRAM	-180,979	807,889	23.02
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	25,379,948	30.00
31.00	03100	INTENSIVE CARE UNIT	0	5,808,387	31.00
34.01	03401	NEONATAL INTENSIVE CARE	-8,820	9,280,203	34.01
34.02	03402	PEDIATRIC INTENSIVE CARE	0	1,217,107	34.02
40.00	04000	SUBPROVIDER - IPF	0	1,543,405	40.00
43.00	04300	NURSERY	0	3,521,811	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-2,433,096	12,155,651	50.00
51.00	05100	RECOVERY ROOM	0	1,307,374	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-1,675,413	5,041,975	52.00
53.00	05300	ANESTHESIOLOGY	-1,644,753	800,570	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-3,767	7,311,978	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	1,726,411	55.00
56.00	05600	RADIOISOTOPE	0	598,936	56.00
57.00	05700	CT SCAN	0	1,701,337	57.00
58.00	05800	MRI	0	1,018,840	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	-3,157,011	12,411,972	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	487,609	64.00
65.00	06500	RESPIRATORY THERAPY	-9,630	3,902,649	65.00
66.00	06600	PHYSICAL THERAPY	0	2,127,282	66.00
69.00	06900	ELECTROCARDIOLOGY	-13,836	2,051,670	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	932,818	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	20,745,186	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	11,827,899	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,358,992	26,856,265	73.00
73.01	07301	INJECTABLE DRUGS	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	848,093	74.00
76.00	03340	GI LAB	0	1,289,470	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
90.01	09003	PAIN CENTER	0	759,434	90.01
90.02	09001	ANTENATAL TEST CENTER	0	904,550	90.02
90.03	09002	CHILD PSYCHIATRIC CLINIC	0	156,931	90.03
90.04	09004	SPECIAL SURGICAL SERVICES	0	438,094	90.04
90.05	09005	GENETIC SERVICES	0	333,336	90.05
90.06	09006	HBP	0	0	90.06
90.07	09007	MAIN	0	0	90.07
90.08	09008	RMB	0	0	90.08
90.09	09009	MULFORD	0	0	90.09
90.10	09010	ALPINE	0	0	90.10
90.11	09011	ROSCOE	0	0	90.11
90.12	09012	BYRON	0	0	90.12

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0239

Period:
From 07/01/2019
To 06/30/2020

Worksheet A

Date/Time Prepared:
4/22/2021 7:56 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
90.13	09013	WINNEBAGO	0	0	90.13
90.14	09014	PERRYVILLE	0	0	90.14
90.15	09015	BELVIDERE	0	0	90.15
90.16	09016	SPRINGBROOK	0	0	90.16
90.17	09017	MCFARLAND	0	0	90.17
90.18	09018	CHERRYVALLEY	0	0	90.18
90.19	09019	KLECKNER	0	0	90.19
90.20	09020	GALLERIA	0	0	90.20
90.21	09021	RIVERSIDE MOB	0	0	90.21
90.22	09022	MULFORD-LENOX	0	0	90.22
91.00	09100	EMERGENCY	-133,124	10,285,416	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	-838,085	1,023,896	95.00
99.10	09910	CORF	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	99.40
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-85,457,204	294,540,143	118.00
NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
193.01	19301	BELOIT HEART STANDBY	0	39,070	193.01
194.00	07950	GUEST CENTER	0	268,157	194.00
194.01	07954	OTHER NONREIMBURSEABLE COST CENTER	0	43,288	194.01
194.02	07951	COMMUNITY SERVICES	0	886,733	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERSO	0	0	194.03
194.04	07952	AUXILIARY	0	363,054	194.04
194.05	07956	RETAIL PHARMACY	0	2,954,352	194.05
194.08	07955	DIALYSIS RENTED SPACE	0	0	194.08
200.00		TOTAL (SUM OF LINES 118 through 199)	-85,457,204	299,094,797	200.00

RECLASSIFICATIONS

Provider CCN: 14-0239

Period:
From 07/01/2019
To 06/30/2020

Worksheet A-6

Date/Time Prepared:
4/22/2021 7:56 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - DRUGS CHARGED TO PATIENTS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	24,497,273	1.00	
	TOTALS		0	24,497,273		
	E - SHARED DIETARY EXPENSES					
1.00	CAFETERIA	11.00	1,710,302	1,150,133	1.00	
	TOTALS		1,710,302	1,150,133		
	F - RECLASS MED SUPPLIES CHGD PAT					
1.00	MEDICAL SUPPLIES CHARGED TO	71.00	0	20,745,186	1.00	
	PATIENT					
2.00	PHYSICAL THERAPY	66.00	0	519	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	
7.00		0.00	0	0	7.00	
8.00		0.00	0	0	8.00	
9.00		0.00	0	0	9.00	
10.00		0.00	0	0	10.00	
11.00		0.00	0	0	11.00	
12.00		0.00	0	0	12.00	
13.00		0.00	0	0	13.00	
14.00		0.00	0	0	14.00	
16.00		0.00	0	0	16.00	
17.00		0.00	0	0	17.00	
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	
	TOTALS		0	20,745,705		
	G - NURSERY COSTS					
1.00	NURSERY	43.00	2,880,392	641,419	1.00	
2.00		0.00	0	0	2.00	
	TOTALS		2,880,392	641,419		
	H - DEPARTMENTAL DEPRECIATION					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	32,785,551	1.00	
2.00		0.00	0	0	2.00	
	TOTALS		0	32,785,551		
	I - INSURANCE RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	350,000	1.00	
	TOTALS		0	350,000		
	J - PASTORAL EDUCATION PROGRAM					
1.00	PASTORAL EDUCATION PROGRAM	23.01	117,773	37,853	1.00	
	TOTALS		117,773	37,853		
	K - IMPLANTS					
1.00	IMPL. DEV. CHARGED TO	72.00	0	11,827,899	1.00	
	PATIENTS					
2.00		0.00	0	0	2.00	
3.00		0.00	0	0	3.00	
4.00		0.00	0	0	4.00	
	TOTALS		0	11,827,899		
	O - INTERNS AND RESIDENTS					
1.00	I&R SERVICES-SALARY &	21.00	1,506,090	0	1.00	
	FRINGES APPRV					
2.00	I&R SERVICES-OTHER PRGM	22.00	2,793,176	895,435	2.00	
	COSTS APPRV					
	TOTALS		4,299,266	895,435		
	P - DIRECTOR AND MANAGER					
1.00	OPERATION OF PLANT	7.00	335,496	0	1.00	
2.00	LAUNDRY & LINEN SERVICE	8.00	88,464	0	2.00	
3.00	HOUSEKEEPING	9.00	58,976	0	3.00	
4.00	DIETARY	10.00	125,273	0	4.00	
5.00	NURSING ADMINISTRATION	13.00	208,003	0	5.00	
6.00	CENTRAL SERVICES & SUPPLY	14.00	216,890	0	6.00	
7.00	PHARMACY	15.00	375,769	0	7.00	
8.00	SOCIAL SERVICE	17.00	26,262	0	8.00	
9.00	PARAMED EDUC EMT PROGRAM	23.02	103,900	0	9.00	
10.00	ADULTS & PEDIATRICS	30.00	1,029,775	0	10.00	
11.00	INTENSIVE CARE UNIT	31.00	98,017	0	11.00	
12.00	NEONATAL INTENSIVE CARE	34.01	173,142	0	12.00	
13.00	PEDIATRIC INTENSIVE CARE	34.02	72,962	0	13.00	
14.00	SUBPROVIDER - IPF	40.00	113,779	0	14.00	
15.00	OPERATING ROOM	50.00	459,885	0	15.00	
16.00	RECOVERY ROOM	51.00	53,666	0	16.00	

RECLASSIFICATIONS

Provider CCN: 14-0239

Period:
From 07/01/2019
To 06/30/2020

Worksheet A-6

Date/Time Prepared:
4/22/2021 7:56 am

Increases					
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
17.00	DELIVERY ROOM & LABOR ROOM	52.00	174,580	0	17.00
18.00	ANESTHESIOLOGY	53.00	56,317	0	18.00
19.00	RADIOLOGY-DIAGNOSTIC	54.00	157,273	0	19.00
20.00	RADIOLOGY-THERAPEUTIC	55.00	28,222	0	20.00
21.00	LABORATORY	60.00	192,634	0	21.00
22.00	INTRAVENOUS THERAPY	64.00	62,745	0	22.00
23.00	RESPIRATORY THERAPY	65.00	78,391	0	23.00
24.00	ELECTROCARDIOLOGY	69.00	34,110	0	24.00
25.00	ELECTROENCEPHALOGRAPHY	70.00	67,511	0	25.00
26.00	RENAL DIALYSIS	74.00	14,278	0	26.00
27.00	GI LAB	76.00	117,766	0	27.00
28.00	PAIN CENTER	90.01	41,380	0	28.00
29.00	SPECIAL SURGICAL SERVICES	90.04	14,506	0	29.00
30.00	EMERGENCY	91.00	206,335	0	30.00
31.00	AMBULANCE SERVICES	95.00	13,803	0	31.00
33.00	AUXILIARY	194.04	35,500	0	33.00
	TOTALS		4,835,610	0	
500.00	Grand Total: Increases		13,843,343	92,931,268	500.00

RECLASSIFICATIONS

Provider CCN: 14-0239

Period:
From 07/01/2019
To 06/30/2020

Worksheet A-6

Date/Time Prepared:
4/22/2021 7:56 am

	Decreases							
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.			
	6.00	7.00	8.00	9.00	10.00			
	A - DRUGS CHARGED TO PATIENTS							
1.00	PHARMACY _____	15.00	0	24,497,273	0			1.00
	TOTALS		0	24,497,273				
	E - SHARED DIETARY EXPENSES							
1.00	DIETARY _____	10.00	1,710,302	1,150,133	0			1.00
	TOTALS		1,710,302	1,150,133				
	F - RECLASS MED SUPPLIES CHGD PAT							
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	64,855	0			1.00
2.00	ADULTS & PEDIATRICS	30.00	0	1,790,257	0			2.00
3.00	INTENSIVE CARE UNIT	31.00	0	777,436	0			3.00
4.00	NEONATAL INTENSIVE CARE	34.01	0	1,114,366	0			4.00
5.00	PEDIATRIC INTENSIVE CARE	34.02	0	106,261	0			5.00
7.00	OPERATING ROOM	50.00	0	6,022,236	0			7.00
8.00	RECOVERY ROOM	51.00	0	28,525	0			8.00
9.00	DELIVERY ROOM & LABOR ROOM	52.00	0	728,723	0			9.00
10.00	ANESTHESIOLOGY	53.00	0	634,904	0			10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	0	5,820,585	0			11.00
12.00	RADIOLOGY-THERAPEUTIC	55.00	0	70,053	0			12.00
13.00	RADIOISOTOPE	56.00	0	470,017	0			13.00
14.00	CT SCAN	57.00	0	299,959	0			14.00
16.00	INTRAVENOUS THERAPY	64.00	0	11,286	0			16.00
17.00	RESPIRATORY THERAPY	65.00	0	541,572	0			17.00
19.00	ELECTROCARDIOLOGY	69.00	0	113,914	0			19.00
20.00	RENAL DIALYSIS	74.00	0	6,235	0			20.00
21.00	GI LAB	76.00	0	855,472	0			21.00
22.00	PAIN CENTER	90.01	0	174,292	0			22.00
23.00	SPECIAL SURGICAL SERVICES	90.04	0	92,539	0			23.00
24.00	EMERGENCY _____	91.00	0	1,022,218	0			24.00
	TOTALS		0	20,745,705				
	G - NURSERY COSTS							
1.00	ADULTS & PEDIATRICS	30.00	2,334,803	517,112	0			1.00
2.00	NEONATAL INTENSIVE CARE _____	34.01	545,589	124,307	0			2.00
	TOTALS		2,880,392	641,419				
	H - DEPARTMENTAL DEPRECIATION							
1.00		0.00	0	0	9			1.00
2.00	ADMINISTRATIVE & GENERAL _____	5.00	0	32,785,551	0			2.00
	TOTALS		0	32,785,551				
	I - INSURANCE RECLASS							
1.00	ADMINISTRATIVE & GENERAL _____	5.00	0	350,000	12			1.00
	TOTALS		0	350,000				
	J - PASTORAL EDUCATION PROGRAM							
1.00	ADMINISTRATIVE & GENERAL _____	5.00	117,773	37,853	0			1.00
	TOTALS		117,773	37,853				
	K - IMPLANTS							
1.00	OPERATING ROOM	50.00	0	8,641,482	0			1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	3,185,442	0			2.00
3.00	ANESTHESIOLOGY	53.00	0	110	0			3.00
4.00	SPECIAL SURGICAL SERVICES _____	90.04	0	865	0			4.00
	TOTALS		0	11,827,899				
	O - INTERNS AND RESIDENTS							
1.00	ADMINISTRATIVE & GENERAL	5.00	4,299,266	801,834	0			1.00
2.00	ADULTS & PEDIATRICS _____	30.00	0	93,601	0			2.00
	TOTALS		4,299,266	895,435				
	P - DIRECTOR AND MANAGER							
1.00	ADMINISTRATIVE & GENERAL	5.00	4,835,610	0	0			1.00
2.00		0.00	0	0	0			2.00
3.00		0.00	0	0	0			3.00
4.00		0.00	0	0	0			4.00
5.00		0.00	0	0	0			5.00
6.00		0.00	0	0	0			6.00
7.00		0.00	0	0	0			7.00
8.00		0.00	0	0	0			8.00
9.00		0.00	0	0	0			9.00
10.00		0.00	0	0	0			10.00
11.00		0.00	0	0	0			11.00
12.00		0.00	0	0	0			12.00
13.00		0.00	0	0	0			13.00
14.00		0.00	0	0	0			14.00
15.00		0.00	0	0	0			15.00
16.00		0.00	0	0	0			16.00
17.00		0.00	0	0	0			17.00
18.00		0.00	0	0	0			18.00
19.00		0.00	0	0	0			19.00
20.00		0.00	0	0	0			20.00

RECLASSIFICATIONS

Provider CCN: 14-0239

Period:
From 07/01/2019
To 06/30/2020

Worksheet A-6

Date/Time Prepared:
4/22/2021 7:56 am

Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
21.00		0.00	0	0	0	21.00
22.00		0.00	0	0	0	22.00
23.00		0.00	0	0	0	23.00
24.00		0.00	0	0	0	24.00
25.00		0.00	0	0	0	25.00
26.00		0.00	0	0	0	26.00
27.00		0.00	0	0	0	27.00
28.00		0.00	0	0	0	28.00
29.00		0.00	0	0	0	29.00
30.00		0.00	0	0	0	30.00
31.00		0.00	0	0	0	31.00
33.00		0.00	0	0	0	33.00
	TOTALS		4,835,610	0		
500.00	Grand Total: Decreases		13,843,343	92,931,268		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0239

Period:
From 07/01/2019
To 06/30/2020Worksheet A-7
Part I
Date/Time Prepared:
4/22/2021 7:56 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	8,437,914	0	0	0	63,289	1.00
2.00	Land Improvements	11,344,171	752,751	0	752,751	0	2.00
3.00	Buildings and Fixtures	402,649,798	10,801,194	0	10,801,194	0	3.00
4.00	Building Improvements	263,280	0	0	0	0	4.00
5.00	Fixed Equipment	150,830,651	19,101,780	0	19,101,780	0	5.00
6.00	Movable Equipment	243,927,250	2,693,490	0	2,693,490	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	817,453,064	33,349,215	0	33,349,215	63,289	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	817,453,064	33,349,215	0	33,349,215	63,289	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	8,374,625	0				1.00
2.00	Land Improvements	12,096,922	0				2.00
3.00	Buildings and Fixtures	413,450,992	0				3.00
4.00	Building Improvements	263,280	0				4.00
5.00	Fixed Equipment	169,932,431	0				5.00
6.00	Movable Equipment	246,620,740	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	850,738,990	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	850,738,990	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0239

Period:
From 07/01/2019
To 06/30/2020Worksheet A-7
Part II
Date/Time Prepared:
4/22/2021 7:56 am

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

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0239

Period:
From 07/01/2019
To 06/30/2020Worksheet A-7
Part III
Date/Time Prepared:
4/22/2021 7:56 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	604,118,250	0	604,118,250	0.710110	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	246,620,740	0	246,620,740	0.289890	0	2.00
3.00	Total (sum of lines 1-2)	850,738,990	0	850,738,990	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	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	32,785,551	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	32,785,551	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	350,000	0	0	350,000	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	32,785,551	2.00
3.00	Total (sum of lines 1-2)	0	350,000	0	0	33,135,551	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0239

Period:
From 07/01/2019
To 06/30/2020

Worksheet A-8

Date/Time Prepared:
4/22/2021 7:56 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)	A		0ADMINISTRATIVE & GENERAL	5.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-68,742,156			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	19,365,222			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-2,009,356	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-308	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-26,146	CAFETERIA	11.00	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			0NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0*** Cost Center Deleted ***	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		0*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	340B	A	2,358,992	DRUGS CHARGED TO PATIENTS	73.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0239

Period:
From 07/01/2019
To 06/30/2020

Worksheet A-8

Date/Time Prepared:
4/22/2021 7:56 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
33.01	MISC REV - EMP BEN	B	-9,000	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.01
33.02	MISC REV - ADMIN	B	-155,262	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	MISC REV - PLANT	B	0	OPERATION OF PLANT	7.00	0	33.03
33.04	MISC REV	B	-2,174	SOCIAL SERVICE	17.00	0	33.04
33.05	MISC REV - PARAMED XRAY ED	B	-65,206	PARAMEDICAL ED PROGRAM XRAY	23.00	0	33.05
33.06	MISC REV - PASTORAL ED	B	0	PASTORAL EDUCATION PROGRAM	23.01	0	33.06
33.07	MISC REV - PARAMED EMT ED	B	-180,979	PARAMED EDUC EMT PROGRAM	23.02	0	33.07
33.08	MISC REV - NICU	B	-8,820	NEONATAL INTENSIVE CARE	34.01	0	33.08
33.09	MISC REV - XRAY	B	-3,767	RADIOLOGY-DIAGNOSTIC	54.00	0	33.09
33.10	MISC REV - REF LAB	B	-3,157,011	LABORATORY	60.00	0	33.10
33.11	MISC REV	B	-13,836	ELECTROCARDIOLOGY	69.00	0	33.11
33.12	MISC REV	B	-121,612	EMERGENCY	91.00	0	33.12
33.14	MISC REVENUE	B	-838,085	AMBULANCE SERVICES	95.00	0	33.14
33.16	MISC REV - PHARM	B	0	PHARMACY	15.00	0	33.16
33.17	MISC REV	B	-7,150	OPERATING ROOM	50.00	0	33.17
33.18	MISC REV	B	-9,630	RESPIRATORY THERAPY	65.00	0	33.18
33.19	MISC REV	B	0	PHYSICAL THERAPY	66.00	0	33.19
34.01	INTEREST - ADMIN	A	-18,750,801	ADMINISTRATIVE & GENERAL	5.00	0	34.01
34.02	INTEREST - SURG	A	0	OPERATING ROOM	50.00	0	34.02
35.01	PATIENT PHONE - BLD & FIXT	A	0	CAP REL COSTS-BLDG & FIXT	1.00	9	35.01
35.03	PATIENT PHONE - EMP BEN	A	0	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	35.03
35.04	PATIENT PHONE - ADMIN	A	0	ADMINISTRATIVE & GENERAL	5.00	0	35.04
35.05	PATIENT PHONE - PLANT	A	0	OPERATION OF PLANT	7.00	0	35.05
35.06	PATIENT PHONE - HOUSEKEEP	A	0	HOUSEKEEPING	9.00	0	35.06
37.01	LOBBYING	A	-57,962	ADMINISTRATIVE & GENERAL	5.00	0	37.01
39.01	TAXES - PROV ASSESS	A	-13,022,157	ADMINISTRATIVE & GENERAL	5.00	0	39.01
41.02	PB TO CLINIC	A	0	OPERATING ROOM	50.00	0	41.02
41.03	PB TO CLINIC	A	0	GI LAB	76.00	0	41.03
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-85,457,204				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: 14-0239

Period:
From 07/01/2019
To 06/30/2020

Worksheet A-8-1

Date/Time Prepared:
4/22/2021 7:56 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00	5.00	ADMINISTRATIVE & GENERAL	COVID	2,418,375	1,608,985	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	MNGMT FEE & SHARED SVCS	34,005,801	21,690,146	2.00
3.00	14.00	CENTRAL SERVICES & SUPPLY	SUPPLY CHAIN	720,402	0	3.00
3.01	15.00	PHARMACY	SUPPLY CHAIN	438,558	0	3.01
3.02	4.00	EMPLOYEE BENEFITS DEPARTMENT	EMPLOYEE BENEFITS	2,569,881	0	3.02
3.03	16.00	MEDICAL RECORDS & LIBRARY	MEDICAL RECORDS	2,511,336	0	3.03
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.			42,664,353	23,299,131	5.00

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

	Symbol (1)	Name	Percentage of Ownership	Related Organization(s) and/or Home Office		
	1.00	2.00	3.00	4.00	5.00	

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

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

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

6.00	B	MERCYHEALTH	100.00	MERCYHEALTH	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:					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: 14-0239

Period:
From 07/01/2019
To 06/30/2020

Worksheet A-8-1

Date/Time Prepared:
4/22/2021 7:56 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	809,390	0		1.00
2.00	12,315,655	0		2.00
3.00	720,402	0		3.00
3.01	438,558	0		3.01
3.02	2,569,881	0		3.02
3.03	2,511,336	0		3.03
4.00	0	0		4.00
5.00	19,365,222			5.00

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

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

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

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

6.00	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: 14-0239

Period:
From 07/01/2019
To 06/30/2020

Worksheet A-8-2

Date/Time Prepared:
4/22/2021 7:56 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	0.00		0	0	0	0	0	1.00
2.00	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	63,014,697	62,984,532	30,165	211,500	612	2.00
3.00	0.00	AGGREGATE-	0	0	0	0	0	3.00
4.00	0.00	AGGREGATE-	0	0	0	0	0	4.00
5.00	34.01	AGGREGATE-NEONATAL INTENSIVE CARE	15,000	0	15,000	197,500	247	5.00
6.00	50.00	AGGREGATE-OPERATING ROOM	2,425,946	2,425,946	0	246,400	0	6.00
7.00	52.00	AGGREGATE-DELIVERY ROOM & LABOR ROOM	1,675,413	1,675,413	0	0	0	7.00
8.00	53.00	AGGREGATE-ANESTHESIOLOGY	1,690,000	1,644,753	45,247	239,400	488	8.00
9.00	0.00	AGGREGATE-	0	0	0	0	0	9.00
10.00	0.00	AGGREGATE-	0	0	0	211,500	0	10.00
11.00	0.00	AGGREGATE-	0	0	0	211,500	0	11.00
12.00	0.00	AGGREGATE-	0	0	0	0	0	12.00
13.00	91.00	AGGREGATE-EMERGENCY	42,231	0	42,231	200,300	319	13.00
200.00			68,863,287	68,730,644	132,643		1,666	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	0.00		0	0	0	0	0	1.00
2.00	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	62,230	3,112	0	0	0	2.00
3.00	0.00	AGGREGATE-	0	0	0	0	0	3.00
4.00	0.00	AGGREGATE-	0	0	0	0	0	4.00
5.00	34.01	AGGREGATE-NEONATAL INTENSIVE CARE	23,453	1,173	0	0	0	5.00
6.00	50.00	AGGREGATE-OPERATING ROOM	0	0	0	0	0	6.00
7.00	52.00	AGGREGATE-DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	7.00
8.00	53.00	AGGREGATE-ANESTHESIOLOGY	56,167	2,808	0	0	0	8.00
9.00	0.00	AGGREGATE-	0	0	0	0	0	9.00
10.00	0.00	AGGREGATE-	0	0	0	0	0	10.00
11.00	0.00	AGGREGATE-	0	0	0	0	0	11.00
12.00	0.00	AGGREGATE-	0	0	0	0	0	12.00
13.00	91.00	AGGREGATE-EMERGENCY	30,719	1,536	0	0	0	13.00
200.00			172,569	8,629	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	0.00		0	0	0	0		1.00
2.00	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	0	62,230	0	62,984,532		2.00
3.00	0.00	AGGREGATE-	0	0	0	0		3.00
4.00	0.00	AGGREGATE-	0	0	0	0		4.00
5.00	34.01	AGGREGATE-NEONATAL INTENSIVE CARE	0	23,453	0	0		5.00
6.00	50.00	AGGREGATE-OPERATING ROOM	0	0	0	2,425,946		6.00
7.00	52.00	AGGREGATE-DELIVERY ROOM & LABOR ROOM	0	0	0	1,675,413		7.00
8.00	53.00	AGGREGATE-ANESTHESIOLOGY	0	56,167	0	1,644,753		8.00
9.00	0.00	AGGREGATE-	0	0	0	0		9.00
10.00	0.00	AGGREGATE-	0	0	0	0		10.00
11.00	0.00	AGGREGATE-	0	0	0	0		11.00
12.00	0.00	AGGREGATE-	0	0	0	0		12.00
13.00	91.00	AGGREGATE-EMERGENCY	0	30,719	11,512	11,512		13.00
200.00			0	172,569	11,512	68,742,156		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0239

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part I
Date/Time Prepared:
4/22/2021 7:56 am

Cost Center Description		Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	350,000	350,000			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	32,785,551	32,785,551			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	21,979,330	1,219	25,356	22,005,905	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	21,906,016	122,607	17,387,125	243,964	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	8,491,862	37,847	1,196,727	344,935	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	242,788	1,551	5,305	44,946	8.00
9.00	00900	HOUSEKEEPING	4,554,464	2,775	63,536	610,444	9.00
10.00	01000	DIETARY	1,512,063	4,296	41,112	180,752	10.00
11.00	01100	CAFETERIA	824,933	8,861	84,800	323,892	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	4,306,719	1,455	23,765	728,121	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,634,729	5,904	715,340	356,870	14.00
15.00	01500	PHARMACY	7,353,112	3,348	265,284	930,254	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,158,512	1,414	0	224,706	16.00
17.00	01700	SOCIAL SERVICE	243,968	273	0	42,655	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	1,506,090	0	0	285,219	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	3,688,611	615	0	528,963	22.00
23.00	02300	PARAMEDICAL ED PROGRAM XRAY	241,377	844	91	49,862	23.00
23.01	02301	PASTORAL EDUCATION PROGRAM	155,626	256	0	22,303	23.01
23.02	02302	PARAMED EDUC EMT PROGRAM	807,889	2,808	194,407	113,605	23.02
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	25,379,948	28,217	988,290	4,232,785	30.00
31.00	03100	INTENSIVE CARE UNIT	5,808,387	3,428	354,405	941,427	31.00
34.01	03401	NEONATAL INTENSIVE CARE	9,280,203	4,876	534,316	1,608,276	34.01
34.02	03402	PEDIATRIC INTENSIVE CARE	1,217,107	1,511	28,140	189,736	34.02
40.00	04000	SUBPROVIDER - IPF	1,543,405	3,121	67,406	266,073	40.00
43.00	04300	NURSERY	3,521,811	3,500	178,705	545,480	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	12,155,651	20,209	2,598,169	1,655,825	50.00
51.00	05100	RECOVERY ROOM	1,307,374	1,643	56,195	225,709	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,041,975	4,422	263,600	804,755	52.00
53.00	05300	ANESTHESIOLOGY	800,570	427	85,642	114,163	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,311,978	7,510	2,592,748	1,032,779	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,726,411	3,823	521,168	186,356	55.00
56.00	05600	RADIOISOTOPE	598,936	678	203,032	45,718	56.00
57.00	05700	CT SCAN	1,701,337	336	621,129	224,456	57.00
58.00	05800	MRI	1,018,840	1,808	826,174	147,411	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	12,411,972	7,600	617,801	850,894	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	487,609	0	1,687	81,307	64.00
65.00	06500	RESPIRATORY THERAPY	3,902,649	1,766	270,709	521,650	65.00
66.00	06600	PHYSICAL THERAPY	2,127,282	838	8,768	359,646	66.00
69.00	06900	ELECTROCARDIOLOGY	2,051,670	1,992	152,931	301,885	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	932,818	1,332	69,525	128,464	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	20,745,186	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,827,899	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	26,856,265	0	0	0	73.00
73.01	07301	INJECTABLE DRUGS	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	848,093	867	2,804	2,704	74.00
76.00	03340	GI LAB	1,289,470	1,768	712,861	176,310	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09003	PAIN CENTER	759,434	1,381	142,766	127,574	90.01
90.02	09001	ANTENATAL TEST CENTER	904,550	2,077	135,128	140,621	90.02
90.03	09002	CHILD PSYCHIATRIC CLINIC	156,931	54	1,032	26,728	90.03
90.04	09004	SPECIAL SURGICAL SERVICES	438,094	851	20,093	63,382	90.04
90.05	09005	GENETIC SERVICES	333,336	408	7,316	57,282	90.05
90.06	09006	HBP	0	0	0	0	90.06
90.07	09007	MAIN	0	0	0	0	90.07
90.08	09008	RMB	0	0	0	0	90.08

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0239

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part I
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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	
90.09	09009	MULFORD	0	10,401	0	0	10,401	90.09
90.10	09010	ALPINE	0	5,267	0	0	5,267	90.10
90.11	09011	ROSCOE	0	7,830	0	0	7,830	90.11
90.12	09012	BYRON	0	2,075	0	0	2,075	90.12
90.13	09013	WINNEBAGO	0	2,440	0	0	2,440	90.13
90.14	09014	PERRYVILLE	0	0	0	0	0	90.14
90.15	09015	BELVIDERE	0	0	0	0	0	90.15
90.16	09016	SPRINGBROOK	0	0	0	0	0	90.16
90.17	09017	MCFARLAND	0	0	0	0	0	90.17
90.18	09018	CHERRYVALLEY	0	1,983	0	0	1,983	90.18
90.19	09019	KLECKNER	0	0	0	0	0	90.19
90.20	09020	GALLERIA	0	2,558	0	0	2,558	90.20
90.21	09021	RIVERSIDE MOB	0	0	0	0	0	90.21
90.22	09022	MULFORD-LENOX	0	0	0	0	0	90.22
91.00	09100	EMERGENCY	10,285,416	9,041	663,798	1,570,214	12,528,469	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	1,023,896	1,395	21,109	191,153	1,237,553	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	294,540,143	345,506	32,750,295	21,852,254	294,346,742	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.01	19301	BELOIT HEART STANDBY	39,070	0	0	7,009	46,079	193.01
194.00	07950	GUEST CENTER	268,157	0	17,786	2,523	288,466	194.00
194.01	07954	OTHER NONREIMBURSEABLE COST CENTER	43,288	103	0	3,444	46,835	194.01
194.02	07951	COMMUNITY SERVICES	886,733	1,210	5,586	27,122	920,651	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERSO	0	0	0	0	0	194.03
194.04	07952	AUXILIARY	363,054	2,758	7,083	18,472	391,367	194.04
194.05	07956	RETAIL PHARMACY	2,954,352	423	4,801	95,081	3,054,657	194.05
194.08	07955	DIALYSIS RENTED SPACE	0	0	0	0	0	194.08
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	299,094,797	350,000	32,785,551	22,005,905	299,094,797	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0239

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part I
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Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
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	39,659,712					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	1,539,610	0	11,610,981			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	45,034	0	95,651	435,275		8.00
9.00	00900	HOUSEKEEPING	799,696	0	171,069	0	6,201,984	9.00
10.00	01000	DIETARY	265,722	0	264,865	0	175,929	10.00
11.00	01100	CAFETERIA	189,939	0	546,316	0	362,874	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	773,531	0	89,688	0	59,573	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	720,452	0	364,011	12,306	241,783	14.00
15.00	01500	PHARMACY	1,307,344	0	206,401	0	137,096	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	670,279	0	87,175	0	57,903	16.00
17.00	01700	SOCIAL SERVICE	43,858	0	16,816	0	11,169	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	273,837	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	644,835	0	37,923	0	25,189	22.00
23.00	02300	PARAMEDICAL ED PROGRAM XRAY	44,665	0	52,056	0	34,577	23.00
23.01	02301	PASTORAL EDUCATION PROGRAM	27,239	0	15,773	0	10,477	23.01
23.02	02302	PARAMED EDUC EMT PROGRAM	171,017	0	173,123	0	114,991	23.02
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,682,165	0	1,739,706	130,224	1,155,546	30.00
31.00	03100	INTENSIVE CARE UNIT	1,086,546	0	211,353	23,337	140,384	31.00
34.01	03401	NEONATAL INTENSIVE CARE	1,746,948	0	300,642	14,278	199,693	34.01
34.02	03402	PEDIATRIC INTENSIVE CARE	219,597	0	93,137	3,285	61,864	34.02
40.00	04000	SUBPROVIDER - IPF	287,396	0	192,406	2,992	127,800	40.00
43.00	04300	NURSERY	649,620	0	215,798	18,423	143,337	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,511,632	0	1,245,950	78,688	827,584	50.00
51.00	05100	RECOVERY ROOM	243,204	0	101,277	5,040	67,270	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	934,762	0	272,637	35,133	181,091	52.00
53.00	05300	ANESTHESIOLOGY	152,993	0	26,335	0	17,492	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,673,164	0	463,020	20,168	307,547	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	372,660	0	235,695	2,518	156,553	55.00
56.00	05600	RADIOISOTOPE	129,689	0	41,786	31	27,755	56.00
57.00	05700	CT SCAN	389,399	0	20,709	0	13,755	57.00
58.00	05800	MRI	304,858	0	111,486	2,393	74,051	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	2,123,099	0	468,553	4,148	311,222	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	87,228	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	717,996	0	108,880	16	72,320	65.00
66.00	06600	PHYSICAL THERAPY	381,645	0	51,688	93	34,332	66.00
69.00	06900	ELECTROCARDIOLOGY	383,471	0	122,814	650	81,575	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	173,070	0	82,147	3	54,563	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,171,317	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,808,131	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,105,517	0	0	0	0	73.00
73.01	07301	INJECTABLE DRUGS	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	130,623	0	53,467	535	35,514	74.00
76.00	03340	GI LAB	333,319	0	109,018	5,455	72,412	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09003	PAIN CENTER	157,633	0	85,120	2,498	56,539	90.01
90.02	09001	ANTENATAL TEST CENTER	180,750	0	128,072	0	85,068	90.02
90.03	09002	CHILD PSYCHIATRIC CLINIC	28,242	0	3,342	0	2,220	90.03
90.04	09004	SPECIAL SURGICAL SERVICES	79,862	0	52,440	0	34,831	90.04
90.05	09005	GENETIC SERVICES	60,895	0	25,170	0	16,718	90.05
90.06	09006	HBP	0	0	0	0	0	90.06
90.07	09007	MAIN	0	0	0	0	0	90.07
90.08	09008	RMB	0	0	0	0	0	90.08
90.09	09009	MULFORD	1,590	0	641,247	0	0	90.09
90.10	09010	ALPINE	805	0	324,709	0	0	90.10
90.11	09011	ROSCOE	1,197	0	482,763	0	0	90.11
90.12	09012	BYRON	317	0	127,903	0	0	90.12
90.13	09013	WINNEBAGO	373	0	150,421	0	0	90.13

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0239

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part I
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Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
90.14	09014	PERRYVILLE	0	0	0	0	0	90.14
90.15	09015	BELVIDERE	0	0	0	0	0	90.15
90.16	09016	SPRINGBROOK	0	0	0	0	0	90.16
90.17	09017	MCFARLAND	0	0	0	0	0	90.17
90.18	09018	CHERRYVALLEY	303	0	122,277	0	0	90.18
90.19	09019	KLECKNER	0	0	0	0	0	90.19
90.20	09020	GALLERIA	391	0	157,687	0	0	90.20
90.21	09021	RIVERSIDE MOB	0	0	0	0	0	90.21
90.22	09022	MULFORD-LENOX	0	0	0	0	0	90.22
91.00	09100	EMERGENCY	1,915,227	0	557,383	72,814	370,225	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	189,185	0	85,994	65	57,119	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	38,933,877	0	11,333,899	435,093	6,017,941	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.01	19301	BELOIT HEART STANDBY	7,044	0	0	0	0	193.01
194.00	07950	GUEST CENTER	44,098	0	0	182	0	194.00
194.01	07954	OTHER NONREIMBURSEABLE COST CENTER	7,160	0	6,346	0	4,215	194.01
194.02	07951	COMMUNITY SERVICES	140,740	0	74,620	0	49,564	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERSO	0	0	0	0	0	194.03
194.04	07952	AUXILIARY	59,828	0	170,026	0	112,935	194.04
194.05	07956	RETAIL PHARMACY	466,965	0	26,090	0	17,329	194.05
194.08	07955	DIALYSIS RENTED SPACE	0	0	0	0	0	194.08
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)	39,659,712	0	11,610,981	435,275	6,201,984	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0239

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part I
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Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
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
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	2,444,739					10.00
11.00	01100	CAFETERIA	0	2,341,615				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	79,293	0	6,062,145		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	72,694	0	0	6,124,089	14.00
15.00	01500	PHARMACY	0	81,979	0	0	29,594	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	29,631	0	33,448	40	16.00
17.00	01700	SOCIAL SERVICE	0	6,363	0	21	359	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	39,387	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	18,272	0	0	0	22.00
23.00	02300	PARAMDICAL ED PROGRAM XRAY	0	4,650	0	0	1,131	23.00
23.01	02301	PASTORAL EDUCATION PROGRAM	0	2,372	0	0	0	23.01
23.02	02302	PARAMED EDUC EMT PROGRAM	0	15,522	0	30	4,905	23.02
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,085,993	547,337	0	1,911,371	75,819	30.00
31.00	03100	INTENSIVE CARE UNIT	295,233	101,917	0	459,687	11,741	31.00
34.01	03401	NEONATAL INTENSIVE CARE	0	178,916	0	894,645	9,608	34.01
34.02	03402	PEDIATRIC INTENSIVE CARE	54,818	18,382	0	95,286	862	34.02
40.00	04000	SUBPROVIDER - IPF	0	34,344	0	69,011	4,447	40.00
43.00	04300	NURSERY	0	65,263	0	305,385	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	170,023	0	582,401	138,847	50.00
51.00	05100	RECOVERY ROOM	0	22,372	0	116,167	1,063	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	89,206	0	415,294	9,619	52.00
53.00	05300	ANESTHESIOLOGY	0	11,500	0	45,023	932	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	121,822	0	113,774	107,922	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	18,130	0	44,069	3,399	55.00
56.00	05600	RADIOISOTOPE	0	5,216	0	43	152	56.00
57.00	05700	CT SCAN	0	26,143	0	758	2,836	57.00
58.00	05800	MRI	0	14,218	0	2,822	5,315	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	118,476	0	26	847,776	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	8,547	0	30,374	941	64.00
65.00	06500	RESPIRATORY THERAPY	0	59,953	0	1,379	107,200	65.00
66.00	06600	PHYSICAL THERAPY	0	36,622	0	0	1,161	66.00
69.00	06900	ELECTROCARDIOLOGY	0	33,339	0	61,263	12,141	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	15,569	0	0	11,921	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	2,979,042	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1,698,510	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	INJECTABLE DRUGS	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	141	0	38	1,053	74.00
76.00	03340	GI LAB	0	22,467	0	67,939	1,175	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09003	PAIN CENTER	0	16,748	0	56,713	1,182	90.01
90.02	09001	ANTENATAL TEST CENTER	0	15,931	0	24,874	3,445	90.02
90.03	09002	CHILD PSYCHIATRIC CLINIC	0	1,257	0	0	529	90.03
90.04	09004	SPECIAL SURGICAL SERVICES	0	6,253	0	34,112	227	90.04
90.05	09005	GENETIC SERVICES	0	6,960	0	0	227	90.05
90.06	09006	HBP	0	0	0	0	0	90.06
90.07	09007	MAIN	0	0	0	0	0	90.07
90.08	09008	RMB	0	0	0	0	0	90.08
90.09	09009	MULFORD	0	0	0	0	0	90.09
90.10	09010	ALPINE	0	0	0	0	0	90.10
90.11	09011	ROSCOE	0	0	0	0	0	90.11
90.12	09012	BYRON	0	0	0	0	0	90.12

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0239

Period:
From 07/01/2019
To 06/30/2020Worksheet B
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Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
90.13	09013	WINNEBAGO	0	0	0	0	0	90.13
90.14	09014	PERRYVILLE	0	0	0	0	0	90.14
90.15	09015	BELVIDERE	0	0	0	0	0	90.15
90.16	09016	SPRINGBROOK	0	0	0	0	0	90.16
90.17	09017	MCFARLAND	0	0	0	0	0	90.17
90.18	09018	CHERRYVALLEY	0	0	0	0	0	90.18
90.19	09019	KLECKNER	0	0	0	0	0	90.19
90.20	09020	GALLERIA	0	0	0	0	0	90.20
90.21	09021	RIVERSIDE MOB	0	0	0	0	0	90.21
90.22	09022	MULFORD-LENOX	0	0	0	0	0	90.22
91.00	09100	EMERGENCY	8,695	190,212	0	639,314	25,800	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	17,015	0	50,714	5,335	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,444,739	2,324,442	0	6,055,981	6,106,256	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.01	19301	BELOIT HEART STANDBY	0	220	0	0	0	193.01
194.00	07950	GUEST CENTER	0	597	0	0	339	194.00
194.01	07954	OTHER NONREIMBURSEABLE COST CENTER	0	0	0	0	158	194.01
194.02	07951	COMMUNITY SERVICES	0	2,137	0	6,164	1,123	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERSO	0	0	0	0	0	194.03
194.04	07952	AUXILIARY	0	3,441	0	0	16,008	194.04
194.05	07956	RETAIL PHARMACY	0	10,778	0	0	205	194.05
194.08	07955	DIALYSIS RENTED SPACE	0	0	0	0	0	194.08
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)	2,444,739	2,341,615	0	6,062,145	6,124,089	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0239

Period:
From 07/01/2019
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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
			15.00	16.00	17.00	19.00	20.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	10,314,412					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	5,263,108				16.00
17.00	01700	SOCIAL SERVICE	0	0	365,482			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
20.00	02000	NURSING SCHOOL	0	0	0		0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0			22.00
23.00	02300	PARAMDICAL ED PROGRAM XRAY	0	0	0			23.00
23.01	02301	PASTORAL EDUCATION PROGRAM	0	0	0			23.01
23.02	02302	PARAMED EDUC EMT PROGRAM	20,646	0	0			23.02
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	97,352	264,366	311,274	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	28,205	73,894	0	0	0	31.00
34.01	03401	NEONATAL INTENSIVE CARE	12,199	272,379	4,767	0	0	34.01
34.02	03402	PEDIATRIC INTENSIVE CARE	4,908	16,972	1,355	0	0	34.02
40.00	04000	SUBPROVIDER - IPF	1	18,682	45,422	0	0	40.00
43.00	04300	NURSERY	0	61,600	2,664	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	54,849	279,714	0	0	0	50.00
51.00	05100	RECOVERY ROOM	4,220	34,090	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	23,098	118,687	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	29,906	59,718	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	22,272	305,525	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	5,205	26,622	0	0	0	55.00
56.00	05600	RADIOISOTOPE	1,238	52,124	0	0	0	56.00
57.00	05700	CT SCAN	18,867	322,691	0	0	0	57.00
58.00	05800	MRI	633	111,268	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	40	594,016	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	6,068	128,791	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	221	136,125	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	40,089	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	41,774	139,292	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	61	47,377	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	688,277	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	282,502	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,115,955	750,319	0	0	0	73.00
73.01	07301	INJECTABLE DRUGS	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	265	7,196	0	0	0	74.00
76.00	03340	GI LAB	4,832	52,571	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09003	PAIN CENTER	7,442	39,843	0	0	0	90.01
90.02	09001	ANTENATAL TEST CENTER	2,223	61,566	0	0	0	90.02
90.03	09002	CHILD PSYCHIATRIC CLINIC	0	559	0	0	0	90.03
90.04	09004	SPECIAL SURGICAL SERVICES	6,398	11,914	0	0	0	90.04
90.05	09005	GENETIC SERVICES	14	1,432	0	0	0	90.05
90.06	09006	HBP	0	146	0	0	0	90.06
90.07	09007	MAIN	0	790	0	0	0	90.07
90.08	09008	RMB	0	438	0	0	0	90.08
90.09	09009	MULFORD	0	113	0	0	0	90.09
90.10	09010	ALPINE	0	97	0	0	0	90.10
90.11	09011	ROSCOE	0	126	0	0	0	90.11
90.12	09012	BYRON	0	28	0	0	0	90.12

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0239

Period:
From 07/01/2019
To 06/30/2020Worksheet B
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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
			15.00	16.00	17.00	19.00	20.00	
90.13	09013	WINNEBAGO	0	69	0	0	0	90.13
90.14	09014	PERRYVILLE	0	533	0	0	0	90.14
90.15	09015	BELVIDERE	0	60	0	0	0	90.15
90.16	09016	SPRINGBROOK	0	140	0	0	0	90.16
90.17	09017	MCFARLAND	0	9	0	0	0	90.17
90.18	09018	CHERRYVALLEY	0	48	0	0	0	90.18
90.19	09019	KLECKNER	0	0	0	0	0	90.19
90.20	09020	GALLERIA	0	170	0	0	0	90.20
90.21	09021	RIVERSIDE MOB	0	131	0	0	0	90.21
90.22	09022	MULFORD-LENOX	0	26	0	0	0	90.22
91.00	09100	EMERGENCY	127,331	256,185	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	1,152	3,798	0	0	0	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	9,637,375	5,263,108	365,482	0	0	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.01	19301	BELOIT HEART STANDBY	0	0	0	0	0	193.01
194.00	07950	GUEST CENTER	0	0	0	0	0	194.00
194.01	07954	OTHER NONREIMBURSEABLE COST CENTER	0	0	0	0	0	194.01
194.02	07951	COMMUNITY SERVICES	0	0	0	0	0	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERSO	0	0	0	0	0	194.03
194.04	07952	AUXILIARY	197	0	0	0	0	194.04
194.05	07956	RETAIL PHARMACY	676,840	0	0	0	0	194.05
194.08	07955	DIALYSIS RENTED SPACE	0	0	0	0	0	194.08
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	10,314,412	5,263,108	365,482	0	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0239

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part I
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Cost Center Description			INTERNS & RESIDENTS		PARAMDICAL ED PROGRAM XRAY	PASTORAL EDUCATION PROGRAM	PARAMED EDUC EMT PROGRAM	
			SERVICES-SALAR Y & FRINGES	SERVICES-OTHER PRGM COSTS				
			APPRV	APPRV				
			21.00	22.00	23.00	23.01	23.02	
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
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
20.00	02000	NURSING SCHOOL						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	2,104,533					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		4,944,408				22.00
23.00	02300	PARAMDICAL ED PROGRAM XRAY			429,253			23.00
23.01	02301	PASTORAL EDUCATION PROGRAM				234,046		23.01
23.02	02302	PARAMED EDUC EMT PROGRAM					1,618,943	23.02
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,104,533	4,944,408	0	147,715	43,003	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	16,318	0	31.00
34.01	03401	NEONATAL INTENSIVE CARE	0	0	0	42,719	86,006	34.01
34.02	03402	PEDIATRIC INTENSIVE CARE	0	0	0	4,657	0	34.02
40.00	04000	SUBPROVIDER - IPF	0	0	0	13,424	0	40.00
43.00	04300	NURSERY	0	0	0	9,213	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	225,134	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	43,003	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	429,253	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	32,885	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	INJECTABLE DRUGS	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03340	GI LAB	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09003	PAIN CENTER	0	0	0	0	0	90.01
90.02	09001	ANTENATAL TEST CENTER	0	0	0	0	0	90.02
90.03	09002	CHILD PSYCHIATRIC CLINIC	0	0	0	0	0	90.03
90.04	09004	SPECIAL SURGICAL SERVICES	0	0	0	0	0	90.04
90.05	09005	GENETIC SERVICES	0	0	0	0	0	90.05
90.06	09006	HBP	0	0	0	0	0	90.06
90.07	09007	MAIN	0	0	0	0	0	90.07
90.08	09008	RMB	0	0	0	0	0	90.08
90.09	09009	MULFORD	0	0	0	0	0	90.09
90.10	09010	ALPINE	0	0	0	0	0	90.10

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0239

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part I
Date/Time Prepared:
4/22/2021 7:56 am

Cost Center Description			INTERNS & RESIDENTS		PARAMDICAL ED PROGRAM XRAY	PASTORAL EDUCATION PROGRAM	PARAMED EDUC EMT PROGRAM	
			SERVICES-SALAR Y & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
			21.00	22.00		23.01	23.02	
90.11	09011	ROSCOE	0	0	0	0	0	90.11
90.12	09012	BYRON	0	0	0	0	0	90.12
90.13	09013	WINNEBAGO	0	0	0	0	0	90.13
90.14	09014	PERRYVILLE	0	0	0	0	0	90.14
90.15	09015	BELVIDERE	0	0	0	0	0	90.15
90.16	09016	SPRINGBROOK	0	0	0	0	0	90.16
90.17	09017	MCFARLAND	0	0	0	0	0	90.17
90.18	09018	CHERRYVALLEY	0	0	0	0	0	90.18
90.19	09019	KLECKNER	0	0	0	0	0	90.19
90.20	09020	GALLERIA	0	0	0	0	0	90.20
90.21	09021	RIVERSIDE MOB	0	0	0	0	0	90.21
90.22	09022	MULFORD-LENOX	0	0	0	0	0	90.22
91.00	09100	EMERGENCY	0	0	0	0	1,188,912	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92.00
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,104,533	4,944,408	429,253	234,046	1,618,943	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.01	19301	BELOIT HEART STANDBY	0	0	0	0	0	193.01
194.00	07950	GUEST CENTER	0	0	0	0	0	194.00
194.01	07954	OTHER NONREIMBURSEABLE COST CENTER	0	0	0	0	0	194.01
194.02	07951	COMMUNITY SERVICES	0	0	0	0	0	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERSO	0	0	0	0	0	194.03
194.04	07952	AUXILIARY	0	0	0	0	0	194.04
194.05	07956	RETAIL PHARMACY	0	0	0	0	0	194.05
194.08	07955	DIALYSIS RENTED SPACE	0	0	0	0	0	194.08
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,104,533	4,944,408	429,253	234,046	1,618,943	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0239

Period:
From 07/01/2019
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Part I
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Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
6.00	00600	MAINTENANCE & REPAIRS				6.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
12.00	01200	MAINTENANCE OF PERSONNEL				12.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS				19.00
20.00	02000	NURSING SCHOOL				20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV				22.00
23.00	02300	PARAMDICAL ED PROGRAM XRAY				23.00
23.01	02301	PASTORAL EDUCATION PROGRAM				23.01
23.02	02302	PARAMED EDUC EMT PROGRAM				23.02
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	50,870,052	-7,048,941	43,821,111	30.00
31.00	03100	INTENSIVE CARE UNIT	9,556,262	0	9,556,262	31.00
34.01	03401	NEONATAL INTENSIVE CARE	15,190,471	0	15,190,471	34.01
34.02	03402	PEDIATRIC INTENSIVE CARE	2,011,617	0	2,011,617	34.02
40.00	04000	SUBPROVIDER - IPF	2,675,930	0	2,675,930	40.00
43.00	04300	NURSERY	5,720,799	0	5,720,799	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	22,544,676	0	22,544,676	50.00
51.00	05100	RECOVERY ROOM	2,185,624	0	2,185,624	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,237,282	0	8,237,282	52.00
53.00	05300	ANESTHESIOLOGY	1,344,701	0	1,344,701	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,509,482	0	14,509,482	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	3,302,609	0	3,302,609	55.00
56.00	05600	RADIOISOTOPE	1,106,398	0	1,106,398	56.00
57.00	05700	CT SCAN	3,342,416	0	3,342,416	57.00
58.00	05800	MRI	2,621,277	0	2,621,277	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000	LABORATORY	18,355,623	0	18,355,623	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	832,552	0	832,552	64.00
65.00	06500	RESPIRATORY THERAPY	5,933,749	0	5,933,749	65.00
66.00	06600	PHYSICAL THERAPY	3,042,164	0	3,042,164	66.00
69.00	06900	ELECTROCARDIOLOGY	3,384,797	0	3,384,797	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,516,850	0	1,516,850	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	27,583,822	0	27,583,822	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	15,617,042	0	15,617,042	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	40,828,056	0	40,828,056	73.00
73.01	07301	INJECTABLE DRUGS	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	1,083,300	0	1,083,300	74.00
76.00	03340	GI LAB	2,849,597	0	2,849,597	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	90.00
90.01	09003	PAIN CENTER	1,454,873	0	1,454,873	90.01
90.02	09001	ANTENATAL TEST CENTER	1,684,305	0	1,684,305	90.02
90.03	09002	CHILD PSYCHIATRIC CLINIC	220,894	0	220,894	90.03
90.04	09004	SPECIAL SURGICAL SERVICES	748,457	0	748,457	90.04
90.05	09005	GENETIC SERVICES	509,758	0	509,758	90.05
90.06	09006	HBP	146	0	146	90.06
90.07	09007	MAIN	790	0	790	90.07
90.08	09008	RMB	438	0	438	90.08
90.09	09009	MULFORD	653,351	0	653,351	90.09
90.10	09010	ALPINE	330,878	0	330,878	90.10

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0239

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part I
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Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
			24.00	25.00	26.00		
90.11	09011	ROSCOE	491,916	0	491,916		90.11
90.12	09012	BYRON	130,323	0	130,323		90.12
90.13	09013	WINNEBAGO	153,303	0	153,303		90.13
90.14	09014	PERRYVILLE	533	0	533		90.14
90.15	09015	BELVIDERE	60	0	60		90.15
90.16	09016	SPRINGBROOK	140	0	140		90.16
90.17	09017	MCFARLAND	9	0	9		90.17
90.18	09018	CHERRYVALLEY	124,611	0	124,611		90.18
90.19	09019	KLECKNER	0	0	0		90.19
90.20	09020	GALLERIA	160,806	0	160,806		90.20
90.21	09021	RIVERSIDE MOB	131	0	131		90.21
90.22	09022	MULFORD-LENOX	26	0	26		90.22
91.00	09100	EMERGENCY	17,880,567	0	17,880,567		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0			92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	1,647,930	0	1,647,930		95.00
99.10	09910	CORF	0	0	0		99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0		99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0		99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0		99.40
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	292,441,393	-7,048,941	285,392,452		118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0		192.00
193.01	19301	BELOIT HEART STANDBY	53,343	0	53,343		193.01
194.00	07950	GUEST CENTER	333,682	0	333,682		194.00
194.01	07954	OTHER NONREIMBURSEABLE COST CENTER	64,714	0	64,714		194.01
194.02	07951	COMMUNITY SERVICES	1,194,999	0	1,194,999		194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERSO	0	0	0		194.03
194.04	07952	AUXILIARY	753,802	0	753,802		194.04
194.05	07956	RETAIL PHARMACY	4,252,864	0	4,252,864		194.05
194.08	07955	DIALYSIS RENTED SPACE	0	0	0		194.08
200.00		Cross Foot Adjustments	0	0	0		200.00
201.00		Negative Cost Centers	0	0	0		201.00
202.00		TOTAL (sum lines 118 through 201)	299,094,797	-7,048,941	292,045,856		202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0239

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	1,219	25,356	26,575	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,102,746	122,607	17,387,125	19,612,478	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	3,167	37,847	1,196,727	1,237,741	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,551	5,305	6,856	8.00
9.00	00900	HOUSEKEEPING	1,636	2,775	63,536	67,947	9.00
10.00	01000	DIETARY	2,116	4,296	41,112	47,524	10.00
11.00	01100	CAFETERIA	1,425	8,861	84,800	95,086	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	5,395	1,455	23,765	30,615	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	318,568	5,904	715,340	1,039,812	14.00
15.00	01500	PHARMACY	1,217,963	3,348	265,284	1,486,595	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,414	0	1,414	16.00
17.00	01700	SOCIAL SERVICE	0	273	0	273	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	615	0	615	22.00
23.00	02300	PARAMDICAL ED PROGRAM XRAY	1,639	844	91	2,574	23.00
23.01	02301	PASTORAL EDUCATION PROGRAM	0	256	0	256	23.01
23.02	02302	PARAMED EDUC EMT PROGRAM	3,714	2,808	194,407	200,929	23.02
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	497	28,217	988,290	1,017,004	30.00
31.00	03100	INTENSIVE CARE UNIT	0	3,428	354,405	357,833	31.00
34.01	03401	NEONATAL INTENSIVE CARE	1,872	4,876	534,316	541,064	34.01
34.02	03402	PEDIATRIC INTENSIVE CARE	0	1,511	28,140	29,651	34.02
40.00	04000	SUBPROVIDER - IPF	0	3,121	67,406	70,527	40.00
43.00	04300	NURSERY	0	3,500	178,705	182,205	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	20,209	2,598,169	2,618,378	50.00
51.00	05100	RECOVERY ROOM	0	1,643	56,195	57,838	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	13,800	4,422	263,600	281,822	52.00
53.00	05300	ANESTHESIOLOGY	0	427	85,642	86,069	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	123	7,510	2,592,748	2,600,381	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	2,850	3,823	521,168	527,841	55.00
56.00	05600	RADIOISOTOPE	0	678	203,032	203,710	56.00
57.00	05700	CT SCAN	0	336	621,129	621,465	57.00
58.00	05800	MRI	0	1,808	826,174	827,982	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	111,861	7,600	617,801	737,262	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	1,687	1,687	64.00
65.00	06500	RESPIRATORY THERAPY	29,296	1,766	270,709	301,771	65.00
66.00	06600	PHYSICAL THERAPY	0	838	8,768	9,606	66.00
69.00	06900	ELECTROCARDIOLOGY	0	1,992	152,931	154,923	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	101,045	1,332	69,525	171,902	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
73.01	07301	INJECTABLE DRUGS	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	867	2,804	3,671	74.00
76.00	03340	GI LAB	178,874	1,768	712,861	893,503	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09003	PAIN CENTER	0	1,381	142,766	144,147	90.01
90.02	09001	ANTENATAL TEST CENTER	0	2,077	135,128	137,205	90.02
90.03	09002	CHILD PSYCHIATRIC CLINIC	0	54	1,032	1,086	90.03
90.04	09004	SPECIAL SURGICAL SERVICES	52,884	851	20,093	73,828	90.04
90.05	09005	GENETIC SERVICES	0	408	7,316	7,724	90.05
90.06	09006	HBP	0	0	0	0	90.06
90.07	09007	MAIN	0	0	0	0	90.07
90.08	09008	RMB	0	0	0	0	90.08
90.09	09009	MULFORD	0	10,401	0	10,401	90.09

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0239

Period:
From 07/01/2019
To 06/30/2020Worksheet B
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Cost Center Description			Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
				BLDG & FIXT	MVBLE EQUIP			
				1.00	2.00	2A	4.00	
90.10	09010	ALPINE	0	5,267	0	5,267	0	90.10
90.11	09011	ROSCOE	0	7,830	0	7,830	0	90.11
90.12	09012	BYRON	0	2,075	0	2,075	0	90.12
90.13	09013	WINNEBAGO	0	2,440	0	2,440	0	90.13
90.14	09014	PERRYVILLE	0	0	0	0	0	90.14
90.15	09015	BELVIDERE	0	0	0	0	0	90.15
90.16	09016	SPRINGBROOK	0	0	0	0	0	90.16
90.17	09017	MCFARLAND	0	0	0	0	0	90.17
90.18	09018	CHERRYVALLEY	0	1,983	0	1,983	0	90.18
90.19	09019	KLECKNER	0	0	0	0	0	90.19
90.20	09020	GALLERIA	0	2,558	0	2,558	0	90.20
90.21	09021	RIVERSIDE MOB	0	0	0	0	0	90.21
90.22	09022	MULFORD-LENOX	0	0	0	0	0	90.22
91.00	09100	EMERGENCY	1,959	9,041	663,798	674,798	1,899	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS				0		92.00
95.00	09500	AMBULANCE SERVICES	0	1,395	21,109	22,504	231	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,153,430	345,506	32,750,295	37,249,231	26,390	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.01	19301	BELOIT HEART STANDBY	0	0	0	0	8	193.01
194.00	07950	GUEST CENTER	0	0	17,786	17,786	3	194.00
194.01	07954	OTHER NONREIMBURSEABLE COST CENTER	0	103	0	103	4	194.01
194.02	07951	COMMUNITY SERVICES	0	1,210	5,586	6,796	33	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.03
194.04	07952	AUXILIARY	0	2,758	7,083	9,841	22	194.04
194.05	07956	RETAIL PHARMACY	0	423	4,801	5,224	115	194.05
194.08	07955	DIALYSIS RENTED SPACE	0	0	0	0	0	194.08
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	4,153,430	350,000	32,785,551	37,288,981	26,575	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0239

Period:
From 07/01/2019
To 06/30/2020Worksheet B
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Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
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	19,612,773					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	761,376	0	1,999,534			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	22,270	0	16,472	45,652		8.00
9.00	00900	HOUSEKEEPING	395,470	0	29,460	0	493,615	9.00
10.00	01000	DIETARY	131,406	0	45,613	0	14,002	10.00
11.00	01100	CAFETERIA	93,929	0	94,081	0	28,881	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	382,530	0	15,445	0	4,741	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	356,282	0	62,687	1,291	19,244	14.00
15.00	01500	PHARMACY	646,514	0	35,545	0	10,911	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	331,469	0	15,012	0	4,608	16.00
17.00	01700	SOCIAL SERVICE	21,689	0	2,896	0	889	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	135,419	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	318,887	0	6,531	0	2,005	22.00
23.00	02300	PARAMEDICAL ED PROGRAM XRAY	22,088	0	8,965	0	2,752	23.00
23.01	02301	PASTORAL EDUCATION PROGRAM	13,470	0	2,716	0	834	23.01
23.02	02302	PARAMED EDUC EMT PROGRAM	84,572	0	29,814	0	9,152	23.02
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,315,510	0	299,596	13,656	91,969	30.00
31.00	03100	INTENSIVE CARE UNIT	537,324	0	36,397	2,448	11,173	31.00
34.01	03401	NEONATAL INTENSIVE CARE	863,909	0	51,774	1,498	15,893	34.01
34.02	03402	PEDIATRIC INTENSIVE CARE	108,596	0	16,039	345	4,924	34.02
40.00	04000	SUBPROVIDER - IPF	142,125	0	33,134	314	10,172	40.00
43.00	04300	NURSERY	321,253	0	37,163	1,932	11,408	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,242,064	0	214,566	8,253	65,867	50.00
51.00	05100	RECOVERY ROOM	120,270	0	17,441	529	5,354	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	462,263	0	46,951	3,685	14,413	52.00
53.00	05300	ANESTHESIOLOGY	75,659	0	4,535	0	1,392	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	827,421	0	79,737	2,115	24,478	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	184,290	0	40,589	264	12,460	55.00
56.00	05600	RADIOISOTOPE	64,135	0	7,196	3	2,209	56.00
57.00	05700	CT SCAN	192,568	0	3,566	0	1,095	57.00
58.00	05800	MRI	150,760	0	19,199	251	5,894	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	1,049,925	0	80,690	435	24,770	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	43,136	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	355,067	0	18,750	2	5,756	65.00
66.00	06600	PHYSICAL THERAPY	188,733	0	8,901	10	2,733	66.00
69.00	06900	ELECTROCARDIOLOGY	189,636	0	21,150	68	6,493	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	85,587	0	14,147	0	4,343	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,568,295	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	894,166	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,030,280	0	0	0	0	73.00
73.01	07301	INJECTABLE DRUGS	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	64,596	0	9,208	56	2,827	74.00
76.00	03340	GI LAB	164,835	0	18,774	572	5,763	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09003	PAIN CENTER	77,953	0	14,659	262	4,500	90.01
90.02	09001	ANTENATAL TEST CENTER	89,385	0	22,055	0	6,771	90.02
90.03	09002	CHILD PSYCHIATRIC CLINIC	13,966	0	575	0	177	90.03
90.04	09004	SPECIAL SURGICAL SERVICES	39,494	0	9,031	0	2,772	90.04
90.05	09005	GENETIC SERVICES	30,114	0	4,335	0	1,331	90.05
90.06	09006	HBP	0	0	0	0	0	90.06
90.07	09007	MAIN	0	0	0	0	0	90.07
90.08	09008	RMB	0	0	0	0	0	90.08
90.09	09009	MULFORD	786	0	110,430	0	0	90.09
90.10	09010	ALPINE	398	0	55,918	0	0	90.10
90.11	09011	ROSCOE	592	0	83,137	0	0	90.11
90.12	09012	BYRON	157	0	22,026	0	0	90.12
90.13	09013	WINNEBAGO	184	0	25,904	0	0	90.13

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0239

Period:
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To 06/30/2020Worksheet B
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Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
90.14	09014	PERRYVILLE	0	0	0	0	0	90.14
90.15	09015	BELVIDERE	0	0	0	0	0	90.15
90.16	09016	SPRINGBROOK	0	0	0	0	0	90.16
90.17	09017	MC FARLAND	0	0	0	0	0	90.17
90.18	09018	CHERRY VALLEY	150	0	21,057	0	0	90.18
90.19	09019	KLECKNER	0	0	0	0	0	90.19
90.20	09020	GALLERIA	193	0	27,155	0	0	90.20
90.21	09021	RIVERSIDE MOB	0	0	0	0	0	90.21
90.22	09022	MULFORD-LENOX	0	0	0	0	0	90.22
91.00	09100	EMERGENCY	947,127	0	95,987	7,637	29,466	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	93,557	0	14,809	7	4,546	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	19,253,830	0	1,951,818	45,633	478,968	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.01	19301	BELOIT HEART STANDBY	3,483	0	0	0	0	193.01
194.00	07950	GUEST CENTER	21,807	0	0	19	0	194.00
194.01	07954	OTHER NONREIMBURSEABLE COST CENTER	3,541	0	1,093	0	335	194.01
194.02	07951	COMMUNITY SERVICES	69,599	0	12,850	0	3,945	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERSO	0	0	0	0	0	194.03
194.04	07952	AUXILIARY	29,587	0	29,280	0	8,988	194.04
194.05	07956	RETAIL PHARMACY	230,926	0	4,493	0	1,379	194.05
194.08	07955	DIALYSIS RENTED SPACE	0	0	0	0	0	194.08
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)	19,612,773	0	1,999,534	45,652	493,615	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0239

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
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
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	238,764					10.00
11.00	01100	CAFETERIA	0	312,369				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	10,578	0	444,789		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	9,697	0	0	1,489,445	14.00
15.00	01500	PHARMACY	0	10,936	0	0	7,198	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	3,953	0	2,454	10	16.00
17.00	01700	SOCIAL SERVICE	0	849	0	2	87	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	5,254	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	2,437	0	0	0	22.00
23.00	02300	PARAMDICAL ED PROGRAM XRAY	0	620	0	0	275	23.00
23.01	02301	PASTORAL EDUCATION PROGRAM	0	316	0	0	0	23.01
23.02	02302	PARAMED EDUC EMT PROGRAM	0	2,071	0	2	1,193	23.02
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	203,727	73,015	0	140,241	18,440	30.00
31.00	03100	INTENSIVE CARE UNIT	28,834	13,596	0	33,728	2,855	31.00
34.01	03401	NEONATAL INTENSIVE CARE	0	23,867	0	65,641	2,337	34.01
34.02	03402	PEDIATRIC INTENSIVE CARE	5,354	2,452	0	6,991	210	34.02
40.00	04000	SUBPROVIDER - IPF	0	4,581	0	5,063	1,082	40.00
43.00	04300	NURSERY	0	8,706	0	22,407	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	22,681	0	42,732	33,769	50.00
51.00	05100	RECOVERY ROOM	0	2,984	0	8,523	259	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	11,900	0	30,471	2,339	52.00
53.00	05300	ANESTHESIOLOGY	0	1,534	0	3,303	227	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	16,251	0	8,348	26,248	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	2,419	0	3,233	827	55.00
56.00	05600	RADIOISOTOPE	0	696	0	3	37	56.00
57.00	05700	CT SCAN	0	3,487	0	56	690	57.00
58.00	05800	MRI	0	1,897	0	207	1,293	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	15,805	0	2	206,191	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	1,140	0	2,229	229	64.00
65.00	06500	RESPIRATORY THERAPY	0	7,998	0	101	26,073	65.00
66.00	06600	PHYSICAL THERAPY	0	4,885	0	0	282	66.00
69.00	06900	ELECTROCARDIOLOGY	0	4,447	0	4,495	2,953	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2,077	0	0	2,899	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	724,526	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	413,101	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	INJECTABLE DRUGS	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	19	0	3	256	74.00
76.00	03340	GI LAB	0	2,997	0	4,985	286	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09003	PAIN CENTER	0	2,234	0	4,161	287	90.01
90.02	09001	ANTENATAL TEST CENTER	0	2,125	0	1,825	838	90.02
90.03	09002	CHILD PSYCHIATRIC CLINIC	0	168	0	0	129	90.03
90.04	09004	SPECIAL SURGICAL SERVICES	0	834	0	2,503	55	90.04
90.05	09005	GENETIC SERVICES	0	928	0	0	55	90.05
90.06	09006	HBP	0	0	0	0	0	90.06
90.07	09007	MAIN	0	0	0	0	0	90.07
90.08	09008	RMB	0	0	0	0	0	90.08
90.09	09009	MULFORD	0	0	0	0	0	90.09
90.10	09010	ALPINE	0	0	0	0	0	90.10
90.11	09011	ROSCOE	0	0	0	0	0	90.11
90.12	09012	BYRON	0	0	0	0	0	90.12

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0239

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part II
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Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
90.13	09013	WINNEBAGO	0	0	0	0	0	90.13
90.14	09014	PERRYVILLE	0	0	0	0	0	90.14
90.15	09015	BELVIDERE	0	0	0	0	0	90.15
90.16	09016	SPRINGBROOK	0	0	0	0	0	90.16
90.17	09017	MCFARLAND	0	0	0	0	0	90.17
90.18	09018	CHERRYVALLEY	0	0	0	0	0	90.18
90.19	09019	KLECKNER	0	0	0	0	0	90.19
90.20	09020	GALLERIA	0	0	0	0	0	90.20
90.21	09021	RIVERSIDE MOB	0	0	0	0	0	90.21
90.22	09022	MULFORD-LENOX	0	0	0	0	0	90.22
91.00	09100	EMERGENCY	849	25,374	0	46,907	6,275	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	2,270	0	3,721	1,298	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	238,764	310,078	0	444,337	1,485,109	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.01	19301	BELOIT HEART STANDBY	0	29	0	0	0	193.01
194.00	07950	GUEST CENTER	0	80	0	0	82	194.00
194.01	07954	OTHER NONREIMBURSEABLE COST CENTER	0	0	0	0	38	194.01
194.02	07951	COMMUNITY SERVICES	0	285	0	452	273	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERSO	0	0	0	0	0	194.03
194.04	07952	AUXILIARY	0	459	0	0	3,893	194.04
194.05	07956	RETAIL PHARMACY	0	1,438	0	0	50	194.05
194.08	07955	DIALYSIS RENTED SPACE	0	0	0	0	0	194.08
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)	238,764	312,369	0	444,789	1,489,445	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0239

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
			15.00	16.00	17.00	19.00	20.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	2,198,824					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	359,192				16.00
17.00	01700	SOCIAL SERVICE	0	0	26,737			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
20.00	02000	NURSING SCHOOL	0	0	0		0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0			22.00
23.00	02300	PARAMDICAL ED PROGRAM XRAY	0	0	0			23.00
23.01	02301	PASTORAL EDUCATION PROGRAM	0	0	0			23.01
23.02	02302	PARAMED EDUC EMT PROGRAM	4,401	0	0			23.02
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	20,753	18,062	22,771			30.00
31.00	03100	INTENSIVE CARE UNIT	6,013	5,049	0			31.00
34.01	03401	NEONATAL INTENSIVE CARE	2,601	18,610	349			34.01
34.02	03402	PEDIATRIC INTENSIVE CARE	1,046	1,160	99			34.02
40.00	04000	SUBPROVIDER - IPF	0	1,276	3,323			40.00
43.00	04300	NURSERY	0	4,209	195			43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	11,693	19,111	0			50.00
51.00	05100	RECOVERY ROOM	900	2,329	0			51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,924	8,109	0			52.00
53.00	05300	ANESTHESIOLOGY	6,375	4,080	0			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,748	20,874	0			54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,109	1,819	0			55.00
56.00	05600	RADIOISOTOPE	264	3,561	0			56.00
57.00	05700	CT SCAN	4,022	22,047	0			57.00
58.00	05800	MRI	135	7,602	0			58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0			59.00
60.00	06000	LABORATORY	9	40,585	0			60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0			62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0			63.00
64.00	06400	INTRAVENOUS THERAPY	1,294	8,799	0			64.00
65.00	06500	RESPIRATORY THERAPY	47	9,300	0			65.00
66.00	06600	PHYSICAL THERAPY	0	2,739	0			66.00
69.00	06900	ELECTROCARDIOLOGY	8,905	9,517	0			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	13	3,237	0			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	47,025	0			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	19,301	0			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,943,338	50,864	0			73.00
73.01	07301	INJECTABLE DRUGS	0	0	0			73.01
74.00	07400	RENAL DIALYSIS	56	492	0			74.00
76.00	03340	GI LAB	1,030	3,592	0			76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0			76.98
76.99	07699	LITHOTRIPSY	0	0	0			76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0			90.00
90.01	09003	PAIN CENTER	1,586	2,722	0			90.01
90.02	09001	ANTENATAL TEST CENTER	474	4,206	0			90.02
90.03	09002	CHILD PSYCHIATRIC CLINIC	0	38	0			90.03
90.04	09004	SPECIAL SURGICAL SERVICES	1,364	814	0			90.04
90.05	09005	GENETIC SERVICES	3	98	0			90.05
90.06	09006	HBP	0	10	0			90.06
90.07	09007	MAIN	0	54	0			90.07
90.08	09008	RMB	0	30	0			90.08
90.09	09009	MULFORD	0	8	0			90.09
90.10	09010	ALPINE	0	7	0			90.10
90.11	09011	ROSCOE	0	9	0			90.11
90.12	09012	BYRON	0	2	0			90.12

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0239

Period:
From 07/01/2019
To 06/30/2020Worksheet B
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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
			15.00	16.00	17.00	19.00	20.00	
90.13	09013	WINNEBAGO	0	5	0			90.13
90.14	09014	PERRYVILLE	0	36	0			90.14
90.15	09015	BELVIDERE	0	4	0			90.15
90.16	09016	SPRINGBROOK	0	10	0			90.16
90.17	09017	MCFARLAND	0	1	0			90.17
90.18	09018	CHERRYVALLEY	0	3	0			90.18
90.19	09019	KLECKNER	0	0	0			90.19
90.20	09020	GALLERIA	0	12	0			90.20
90.21	09021	RIVERSIDE MOB	0	9	0			90.21
90.22	09022	MULFORD-LENOX	0	2	0			90.22
91.00	09100	EMERGENCY	27,144	17,503	0			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	246	260	0			95.00
99.10	09910	CORF	0	0	0			99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0			99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0			99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0			99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,054,493	359,192	26,737	0	0	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0			192.00
193.01	19301	BELOIT HEART STANDBY	0	0	0			193.01
194.00	07950	GUEST CENTER	0	0	0			194.00
194.01	07954	OTHER NONREIMBURSEABLE COST CENTER	0	0	0			194.01
194.02	07951	COMMUNITY SERVICES	0	0	0			194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERSO	0	0	0			194.03
194.04	07952	AUXILIARY	42	0	0			194.04
194.05	07956	RETAIL PHARMACY	144,289	0	0			194.05
194.08	07955	DIALYSIS RENTED SPACE	0	0	0			194.08
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,198,824	359,192	26,737	0	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0239

Period:
From 07/01/2019
To 06/30/2020Worksheet B
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Cost Center Description			INTERNS & RESIDENTS		PARAMDICAL ED PROGRAM XRAY	PASTORAL EDUCATION PROGRAM	PARAMED EDUC EMT PROGRAM	
			SERVICES-SALAR Y & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
			21.00	22.00	23.00	23.01	23.02	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	141,018	331,115	37,334	17,619	332,271	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
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
20.00	02000	NURSING SCHOOL						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV						21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV						22.00
23.00	02300	PARAMDICAL ED PROGRAM XRAY						23.00
23.01	02301	PASTORAL EDUCATION PROGRAM						23.01
23.02	02302	PARAMED EDUC EMT PROGRAM						23.02
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS						30.00
31.00	03100	INTENSIVE CARE UNIT						31.00
34.01	03401	NEONATAL INTENSIVE CARE						34.01
34.02	03402	PEDIATRIC INTENSIVE CARE						34.02
40.00	04000	SUBPROVIDER - IPF						40.00
43.00	04300	NURSERY						43.00
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
55.00	05500	RADIOLOGY-THERAPEUTIC						55.00
56.00	05600	RADIOISOTOPE						56.00
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
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.						63.00
64.00	06400	INTRAVENOUS THERAPY						64.00
65.00	06500	RESPIRATORY THERAPY						65.00
66.00	06600	PHYSICAL THERAPY						66.00
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
73.01	07301	INJECTABLE DRUGS						73.01
74.00	07400	RENAL DIALYSIS						74.00
76.00	03340	GI LAB						76.00
76.97	07697	CARDIAC REHABILITATION						76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY						76.98
76.99	07699	LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC						90.00
90.01	09003	PAIN CENTER						90.01
90.02	09001	ANTENATAL TEST CENTER						90.02
90.03	09002	CHILD PSYCHIATRIC CLINIC						90.03
90.04	09004	SPECIAL SURGICAL SERVICES						90.04
90.05	09005	GENETIC SERVICES						90.05
90.06	09006	HBP						90.06
90.07	09007	MAIN						90.07
90.08	09008	RMB						90.08
90.09	09009	MULFORD						90.09
90.10	09010	ALPINE						90.10

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0239

Period:
From 07/01/2019
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Cost Center Description			INTERNS & RESIDENTS		PARAMDICAL ED PROGRAM XRAY	PASTORAL EDUCATION PROGRAM	PARAMED EDUC EMT PROGRAM	
			SERVICES-SALAR Y & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
			21.00	22.00				
90.11	09011	ROSCOE			23.00	23.01	23.02	90.11
90.12	09012	BYRON						90.12
90.13	09013	WINNEBAGO						90.13
90.14	09014	PERRYVILLE						90.14
90.15	09015	BELVIDERE						90.15
90.16	09016	SPRINGBROOK						90.16
90.17	09017	MCFARLAND						90.17
90.18	09018	CHERRYVALLEY						90.18
90.19	09019	KLECKNER						90.19
90.20	09020	GALLERIA						90.20
90.21	09021	RIVERSIDE MOB						90.21
90.22	09022	MULFORD-LENOX						90.22
91.00	09100	EMERGENCY						91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92.00
95.00	09500	AMBULANCE SERVICES						95.00
99.10	09910	CORF						99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY						99.40
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	0	0	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES						192.00
193.01	19301	BELOIT HEART STANDBY						193.01
194.00	07950	GUEST CENTER						194.00
194.01	07954	OTHER NONREIMBURSEABLE COST CENTER						194.01
194.02	07951	COMMUNITY SERVICES						194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERSO						194.03
194.04	07952	AUXILIARY						194.04
194.05	07956	RETAIL PHARMACY						194.05
194.08	07955	DIALYSIS RENTED SPACE						194.08
200.00		Cross Foot Adjustments	141,018	331,115	37,334	17,619	332,271	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	141,018	331,115	37,334	17,619	332,271	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0239

Period:
From 07/01/2019
To 06/30/2020Worksheet B
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Date/Time Prepared:
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Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
6.00	00600	MAINTENANCE & REPAIRS				6.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
12.00	01200	MAINTENANCE OF PERSONNEL				12.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS				19.00
20.00	02000	NURSING SCHOOL				20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV				22.00
23.00	02300	PARAMDICAL ED PROGRAM XRAY				23.00
23.01	02301	PASTORAL EDUCATION PROGRAM				23.01
23.02	02302	PARAMED EDUC EMT PROGRAM				23.02
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	4,239,830	0	4,239,830	30.00
31.00	03100	INTENSIVE CARE UNIT	1,036,388	0	1,036,388	31.00
34.01	03401	NEONATAL INTENSIVE CARE	1,589,488	0	1,589,488	34.01
34.02	03402	PEDIATRIC INTENSIVE CARE	177,096	0	177,096	34.02
40.00	04000	SUBPROVIDER - IPF	271,919	0	271,919	40.00
43.00	04300	NURSERY	590,138	0	590,138	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,281,116	0	4,281,116	50.00
51.00	05100	RECOVERY ROOM	216,700	0	216,700	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	867,850	0	867,850	52.00
53.00	05300	ANESTHESIOLOGY	183,312	0	183,312	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,611,850	0	3,611,850	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	775,076	0	775,076	55.00
56.00	05600	RADIOISOTOPE	281,869	0	281,869	56.00
57.00	05700	CT SCAN	849,267	0	849,267	57.00
58.00	05800	MRI	1,015,398	0	1,015,398	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000	LABORATORY	2,156,703	0	2,156,703	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	58,612	0	58,612	64.00
65.00	06500	RESPIRATORY THERAPY	725,496	0	725,496	65.00
66.00	06600	PHYSICAL THERAPY	218,324	0	218,324	66.00
69.00	06900	ELECTROCARDIOLOGY	402,952	0	402,952	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	284,360	0	284,360	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,339,846	0	2,339,846	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,326,568	0	1,326,568	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,024,482	0	4,024,482	73.00
73.01	07301	INJECTABLE DRUGS	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	81,187	0	81,187	74.00
76.00	03340	GI LAB	1,096,550	0	1,096,550	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	90.00
90.01	09003	PAIN CENTER	252,665	0	252,665	90.01
90.02	09001	ANTENATAL TEST CENTER	265,054	0	265,054	90.02
90.03	09002	CHILD PSYCHIATRIC CLINIC	16,171	0	16,171	90.03
90.04	09004	SPECIAL SURGICAL SERVICES	130,772	0	130,772	90.04
90.05	09005	GENETIC SERVICES	44,657	0	44,657	90.05
90.06	09006	HBP	10	0	10	90.06
90.07	09007	MAIN	54	0	54	90.07
90.08	09008	RMB	30	0	30	90.08
90.09	09009	MULFORD	121,625	0	121,625	90.09
90.10	09010	ALPINE	61,590	0	61,590	90.10

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0239

Period:
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Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
90.11	09011	ROSCOE	91,568	0	91,568	90.11
90.12	09012	BYRON	24,260	0	24,260	90.12
90.13	09013	WINNEBAGO	28,533	0	28,533	90.13
90.14	09014	PERRYVILLE	36	0	36	90.14
90.15	09015	BELVIDERE	4	0	4	90.15
90.16	09016	SPRINGBROOK	10	0	10	90.16
90.17	09017	MCFARLAND	1	0	1	90.17
90.18	09018	CHERRYVALLEY	23,193	0	23,193	90.18
90.19	09019	KLECKNER	0	0	0	90.19
90.20	09020	GALLERIA	29,918	0	29,918	90.20
90.21	09021	RIVERSIDE MOB	9	0	9	90.21
90.22	09022	MULFORD-LENOX	2	0	2	90.22
91.00	09100	EMERGENCY	1,880,966	0	1,880,966	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0		92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	143,449	0	143,449	95.00
99.10	09910	CORF	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	35,816,954	0	35,816,954	118.00
NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	192.00
193.01	19301	BELOIT HEART STANDBY	3,520	0	3,520	193.01
194.00	07950	GUEST CENTER	39,777	0	39,777	194.00
194.01	07954	OTHER NONREIMBURSEABLE COST CENTER	5,114	0	5,114	194.01
194.02	07951	COMMUNITY SERVICES	94,233	0	94,233	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERSO	0	0	0	194.03
194.04	07952	AUXILIARY	82,112	0	82,112	194.04
194.05	07956	RETAIL PHARMACY	387,914	0	387,914	194.05
194.08	07955	DIALYSIS RENTED SPACE	0	0	0	194.08
200.00		Cross Foot Adjustments	859,357	0	859,357	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	37,288,981	0	37,288,981	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0239

Period:
From 07/01/2019
To 06/30/2020

Worksheet B-1

Date/Time Prepared:
4/22/2021 7:56 am

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	1,407,743				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		32,399,421			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,902	25,057	116,201,469		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	493,151	17,182,350	1,288,245	-39,659,712	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	152,225	1,182,632	1,821,421	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	6,240	5,243	237,336	0	8.00
9.00	00900	HOUSEKEEPING	11,160	62,788	3,223,430	0	9.00
10.00	01000	DIETARY	17,279	40,628	954,458	0	10.00
11.00	01100	CAFETERIA	35,640	83,801	1,710,302	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	5,851	23,485	3,844,822	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	23,747	706,915	1,884,440	0	14.00
15.00	01500	PHARMACY	13,465	262,160	4,912,178	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,687	0	1,186,552	0	16.00
17.00	01700	SOCIAL SERVICE	1,097	0	225,240	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	1,506,090	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	2,474	0	2,793,176	0	22.00
23.00	02300	PARAMEDICAL ED PROGRAM XRAY	3,396	90	263,294	0	23.00
23.01	02301	PASTORAL EDUCATION PROGRAM	1,029	0	117,773	0	23.01
23.02	02302	PARAMED EDUC EMT PROGRAM	11,294	192,117	599,886	0	23.02
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	113,493	976,650	22,351,016	0	30.00
31.00	03100	INTENSIVE CARE UNIT	13,788	350,231	4,971,180	0	31.00
34.01	03401	NEONATAL INTENSIVE CARE	19,613	528,023	8,492,457	0	34.01
34.02	03402	PEDIATRIC INTENSIVE CARE	6,076	27,809	1,001,898	0	34.02
40.00	04000	SUBPROVIDER - IPF	12,552	66,612	1,404,993	0	40.00
43.00	04300	NURSERY	14,078	176,600	2,880,392	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	81,282	2,567,569	8,743,536	0	50.00
51.00	05100	RECOVERY ROOM	6,607	55,533	1,191,848	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	17,786	260,495	4,249,487	0	52.00
53.00	05300	ANESTHESIOLOGY	1,718	84,633	602,835	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	30,206	2,562,212	5,453,560	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	15,376	515,030	984,048	0	55.00
56.00	05600	RADIOISOTOPE	2,726	200,641	241,411	0	56.00
57.00	05700	CT SCAN	1,351	613,814	1,185,232	0	57.00
58.00	05800	MRI	7,273	816,444	778,402	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	30,567	610,525	4,493,123	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	1,667	429,338	0	64.00
65.00	06500	RESPIRATORY THERAPY	7,103	267,521	2,754,556	0	65.00
66.00	06600	PHYSICAL THERAPY	3,372	8,665	1,899,099	0	66.00
69.00	06900	ELECTROCARDIOLOGY	8,012	151,130	1,594,094	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	5,359	68,706	678,353	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
73.01	07301	INJECTABLE DRUGS	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	3,488	2,771	14,278	0	74.00
76.00	03340	GI LAB	7,112	704,465	930,999	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPS	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09003	PAIN CENTER	5,553	141,085	673,653	0	90.01
90.02	09001	ANTENATAL TEST CENTER	8,355	133,537	742,546	0	90.02
90.03	09002	CHILD PSYCHIATRIC CLINIC	218	1,020	141,134	0	90.03
90.04	09004	SPECIAL SURGICAL SERVICES	3,421	19,856	334,685	0	90.04
90.05	09005	GENETIC SERVICES	1,642	7,230	302,478	0	90.05
90.06	09006	HBP	0	0	0	0	90.06
90.07	09007	MAIN	0	0	0	0	90.07
90.08	09008	RMB	0	0	0	0	90.08

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0239

Period:
From 07/01/2019
To 06/30/2020

Worksheet B-1

Date/Time Prepared:
4/22/2021 7:56 am

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	
90.09	09009	MULFORD	41,833	0	0	0	10,401	90.09
90.10	09010	ALPINE	21,183	0	0	0	5,267	90.10
90.11	09011	ROSCOE	31,494	0	0	0	7,830	90.11
90.12	09012	BYRON	8,344	0	0	0	2,075	90.12
90.13	09013	WINNEBAGO	9,813	0	0	0	2,440	90.13
90.14	09014	PERRYVILLE	0	0	0	0	0	90.14
90.15	09015	BELVIDERE	0	0	0	0	0	90.15
90.16	09016	SPRINGBROOK	0	0	0	0	0	90.16
90.17	09017	MCFARLAND	0	0	0	0	0	90.17
90.18	09018	CHERRYVALLEY	7,977	0	0	0	1,983	90.18
90.19	09019	KLECKNER	0	0	0	0	0	90.19
90.20	09020	GALLERIA	10,287	0	0	0	2,558	90.20
90.21	09021	RIVERSIDE MOB	0	0	0	0	0	90.21
90.22	09022	MULFORD-LENOX	0	0	0	0	0	90.22
91.00	09100	EMERGENCY	36,362	655,980	8,291,470	0	12,528,469	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	5,610	20,860	1,009,380	0	1,237,553	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,389,667	32,364,580	115,390,124	-39,659,712	254,687,030	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.01	19301	BELOIT HEART STANDBY	0	0	37,010	0	46,079	193.01
194.00	07950	GUEST CENTER	0	17,577	13,323	0	288,466	194.00
194.01	07954	OTHER NONREIMBURSEABLE COST CENTER	414	0	18,186	0	46,835	194.01
194.02	07951	COMMUNITY SERVICES	4,868	5,520	143,217	0	920,651	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERSO	0	0	0	0	0	194.03
194.04	07952	AUXILIARY	11,092	7,000	97,539	0	391,367	194.04
194.05	07956	RETAIL PHARMACY	1,702	4,744	502,070	0	3,054,657	194.05
194.08	07955	DIALYSIS RENTED SPACE	0	0	0	0	0	194.08
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)	350,000	32,785,551	22,005,905		39,659,712	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.248625	1.011918	0.189377		0.152870	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			26,575		19,612,773	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000229		0.075598	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: 14-0239

Period:
From 07/01/2019
To 06/30/2020

Worksheet B-1

Date/Time Prepared:
4/22/2021 7:56 am

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS	0				6.00
7.00	00700	OPERATION OF PLANT	0	757,465			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	6,240	967,594		8.00
9.00	00900	HOUSEKEEPING	0	11,160	0	609,134	9.00
10.00	01000	DIETARY	0	17,279	0	17,279	227,181 10.00
11.00	01100	CAFETERIA	0	35,640	0	35,640	0 11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0 12.00
13.00	01300	NURSING ADMINISTRATION	0	5,851	0	5,851	0 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	23,747	27,356	23,747	0 14.00
15.00	01500	PHARMACY	0	13,465	0	13,465	0 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	5,687	0	5,687	0 16.00
17.00	01700	SOCIAL SERVICE	0	1,097	0	1,097	0 17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0 19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0 20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0 21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	2,474	0	2,474	0 22.00
23.00	02300	PARAMDICAL ED PROGRAM XRAY	0	3,396	0	3,396	0 23.00
23.01	02301	PASTORAL EDUCATION PROGRAM	0	1,029	0	1,029	0 23.01
23.02	02302	PARAMED EDUC EMT PROGRAM	0	11,294	0	11,294	0 23.02
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	113,493	289,478	113,493	193,844 30.00
31.00	03100	INTENSIVE CARE UNIT	0	13,788	51,878	13,788	27,435 31.00
34.01	03401	NEONATAL INTENSIVE CARE	0	19,613	31,740	19,613	0 34.01
34.02	03402	PEDIATRIC INTENSIVE CARE	0	6,076	7,303	6,076	5,094 34.02
40.00	04000	SUBPROVIDER - IPF	0	12,552	6,651	12,552	0 40.00
43.00	04300	NURSERY	0	14,078	40,953	14,078	0 43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	81,282	174,920	81,282	0 50.00
51.00	05100	RECOVERY ROOM	0	6,607	11,203	6,607	0 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	17,786	78,099	17,786	0 52.00
53.00	05300	ANESTHESIOLOGY	0	1,718	0	1,718	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	30,206	44,833	30,206	0 54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	15,376	5,598	15,376	0 55.00
56.00	05600	RADIOISOTOPE	0	2,726	68	2,726	0 56.00
57.00	05700	CT SCAN	0	1,351	0	1,351	0 57.00
58.00	05800	MRI	0	7,273	5,319	7,273	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0 59.00
60.00	06000	LABORATORY	0	30,567	9,221	30,567	0 60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0 62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0 63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0 64.00
65.00	06500	RESPIRATORY THERAPY	0	7,103	35	7,103	0 65.00
66.00	06600	PHYSICAL THERAPY	0	3,372	207	3,372	0 66.00
69.00	06900	ELECTROCARDIOLOGY	0	8,012	1,446	8,012	0 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	5,359	6	5,359	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
73.01	07301	INJECTABLE DRUGS	0	0	0	0	0 73.01
74.00	07400	RENAL DIALYSIS	0	3,488	1,189	3,488	0 74.00
76.00	03340	GI LAB	0	7,112	12,127	7,112	0 76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0 76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0 76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0 76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0 90.00
90.01	09003	PAIN CENTER	0	5,553	5,553	5,553	0 90.01
90.02	09001	ANTENATAL TEST CENTER	0	8,355	0	8,355	0 90.02
90.03	09002	CHILD PSYCHIATRIC CLINIC	0	218	0	218	0 90.03
90.04	09004	SPECIAL SURGICAL SERVICES	0	3,421	0	3,421	0 90.04
90.05	09005	GENETIC SERVICES	0	1,642	0	1,642	0 90.05
90.06	09006	HBP	0	0	0	0	0 90.06
90.07	09007	MAIN	0	0	0	0	0 90.07
90.08	09008	RMB	0	0	0	0	0 90.08
90.09	09009	MULFORD	0	41,833	0	0	0 90.09
90.10	09010	ALPINE	0	21,183	0	0	0 90.10
90.11	09011	ROSCOE	0	31,494	0	0	0 90.11

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0239

Period:
From 07/01/2019
To 06/30/2020

Worksheet B-1

Date/Time Prepared:
4/22/2021 7:56 am

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	
90.12	09012 BYRON	0	8,344	0	0	0	90.12
90.13	09013 WINNEBAGO	0	9,813	0	0	0	90.13
90.14	09014 PERRYVILLE	0	0	0	0	0	90.14
90.15	09015 BELVIDERE	0	0	0	0	0	90.15
90.16	09016 SPRINGBROOK	0	0	0	0	0	90.16
90.17	09017 MCFARLAND	0	0	0	0	0	90.17
90.18	09018 CHERRYVALLEY	0	7,977	0	0	0	90.18
90.19	09019 KLECKNER	0	0	0	0	0	90.19
90.20	09020 GALLERIA	0	10,287	0	0	0	90.20
90.21	09021 RIVERSIDE MOB	0	0	0	0	0	90.21
90.22	09022 MULFORD-LENOX	0	0	0	0	0	90.22
91.00	09100 EMERGENCY	0	36,362	161,862	36,362	808	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0	5,610	145	5,610	0	95.00
99.10	09910 CORF	0	0	0	0	0	99.10
99.20	09920 OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930 OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940 OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	739,389	967,190	591,058	227,181	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.01	19301 BELOIT HEART STANDBY	0	0	0	0	0	193.01
194.00	07950 GUEST CENTER	0	0	404	0	0	194.00
194.01	07954 OTHER NONREIMBURSEABLE COST CENTER	0	414	0	414	0	194.01
194.02	07951 COMMUNITY SERVICES	0	4,868	0	4,868	0	194.02
194.03	07953 OTHER NONREIMBURSABLE COST CENTERSO	0	0	0	0	0	194.03
194.04	07952 AUXILIARY	0	11,092	0	11,092	0	194.04
194.05	07956 RETAIL PHARMACY	0	1,702	0	1,702	0	194.05
194.08	07955 DIALYSIS RENTED SPACE	0	0	0	0	0	194.08
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	0	11,610,981	435,275	6,201,984	2,444,739	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.000000	15.328736	0.449853	10.181641	10.761195	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	0	1,999,534	45,652	493,615	238,764	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000000	2.639771	0.047181	0.810355	1.050986	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: 14-0239

Period:
From 07/01/2019
To 06/30/2020

Worksheet B-1

Date/Time Prepared:
4/22/2021 7:56 am

Cost Center Description			CAFETERIA (FTE'S)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRSNG HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			11.00	12.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	149,044					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	5,047	0	1,424,018			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,627	0	0	42,646,325		14.00
15.00	01500	PHARMACY	5,218	0	0	206,084	36,295,060	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,886	0	7,857	279	0	16.00
17.00	01700	SOCIAL SERVICE	405	0	5	2,499	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	2,507	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	1,163	0	0	0	0	22.00
23.00	02300	PARAMEDICAL ED PROGRAM XRAY	296	0	0	7,877	0	23.00
23.01	02301	PASTORAL EDUCATION PROGRAM	151	0	0	0	0	23.01
23.02	02302	PARAMED EDUC EMT PROGRAM	988	0	7	34,156	72,649	23.02
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	34,838	0	448,987	527,977	342,568	30.00
31.00	03100	INTENSIVE CARE UNIT	6,487	0	107,982	81,758	99,251	31.00
34.01	03401	NEONATAL INTENSIVE CARE	11,388	0	210,155	66,904	42,926	34.01
34.02	03402	PEDIATRIC INTENSIVE CARE	1,170	0	22,383	6,005	17,272	34.02
40.00	04000	SUBPROVIDER - IPF	2,186	0	16,211	30,966	5	40.00
43.00	04300	NURSERY	4,154	0	71,736	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	10,822	0	136,808	966,886	193,005	50.00
51.00	05100	RECOVERY ROOM	1,424	0	27,288	7,403	14,849	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,678	0	97,554	66,981	81,279	52.00
53.00	05300	ANESTHESIOLOGY	732	0	10,576	6,493	105,237	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,754	0	26,726	751,533	78,374	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,154	0	10,352	23,669	18,314	55.00
56.00	05600	RADIOISOTOPE	332	0	10	1,061	4,355	56.00
57.00	05700	CT SCAN	1,664	0	178	19,749	66,392	57.00
58.00	05800	MRI	905	0	663	37,015	2,229	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	7,541	0	6	5,903,653	142	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	544	0	7,135	6,556	21,353	64.00
65.00	06500	RESPIRATORY THERAPY	3,816	0	324	746,510	776	65.00
66.00	06600	PHYSICAL THERAPY	2,331	0	0	8,087	0	66.00
69.00	06900	ELECTROCARDIOLOGY	2,122	0	14,391	84,547	146,996	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	991	0	0	83,015	214	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	20,745,184	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	11,827,899	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	32,077,848	73.00
73.01	07301	INJECTABLE DRUGS	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	9	0	9	7,331	931	74.00
76.00	03340	GI LAB	1,430	0	15,959	8,181	17,003	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09003	PAIN CENTER	1,066	0	13,322	8,231	26,187	90.01
90.02	09001	ANTENATAL TEST CENTER	1,014	0	5,843	23,989	7,824	90.02
90.03	09002	CHILD PSYCHIATRIC CLINIC	80	0	0	3,687	0	90.03
90.04	09004	SPECIAL SURGICAL SERVICES	398	0	8,013	1,582	22,512	90.04
90.05	09005	GENETIC SERVICES	443	0	0	1,584	51	90.05
90.06	09006	HBP	0	0	0	0	0	90.06
90.07	09007	MAIN	0	0	0	0	0	90.07
90.08	09008	RMB	0	0	0	0	0	90.08
90.09	09009	MULFORD	0	0	0	0	0	90.09
90.10	09010	ALPINE	0	0	0	0	0	90.10

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0239

Period:
From 07/01/2019
To 06/30/2020

Worksheet B-1

Date/Time Prepared:
4/22/2021 7:56 am

Cost Center Description			CAFETERIA (FTE'S)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			11.00	12.00	13.00	14.00	15.00	
90.11	09011	ROSCOE	0	0	0	0	0	90.11
90.12	09012	BYRON	0	0	0	0	0	90.12
90.13	09013	WINNEBAGO	0	0	0	0	0	90.13
90.14	09014	PERRYVILLE	0	0	0	0	0	90.14
90.15	09015	BELVIDERE	0	0	0	0	0	90.15
90.16	09016	SPRINGBROOK	0	0	0	0	0	90.16
90.17	09017	MCFARLAND	0	0	0	0	0	90.17
90.18	09018	CHERRYVALLEY	0	0	0	0	0	90.18
90.19	09019	KLECKNER	0	0	0	0	0	90.19
90.20	09020	GALLERIA	0	0	0	0	0	90.20
90.21	09021	RIVERSIDE MOB	0	0	0	0	0	90.21
90.22	09022	MULFORD-LENOX	0	0	0	0	0	90.22
91.00	09100	EMERGENCY	12,107	0	150,177	179,662	448,060	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92.00
95.00	09500	AMBULANCE SERVICES	1,083	0	11,913	37,153	4,053	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	147,951	0	1,422,570	42,522,146	33,912,655	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.01	19301	BELOIT HEART STANDBY	14	0	0	0	0	193.01
194.00	07950	GUEST CENTER	38	0	0	2,358	0	194.00
194.01	07954	OTHER NONREIMBURSEABLE COST CENTER	0	0	0	1,100	0	194.01
194.02	07951	COMMUNITY SERVICES	136	0	1,448	7,819	0	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERSO	0	0	0	0	0	194.03
194.04	07952	AUXILIARY	219	0	0	111,473	693	194.04
194.05	07956	RETAIL PHARMACY	686	0	0	1,429	2,381,712	194.05
194.08	07955	DIALYSIS RENTED SPACE	0	0	0	0	0	194.08
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,341,615	0	6,062,145	6,124,089	10,314,412	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	15.710897	0.000000	4.257070	0.143602	0.284182	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	312,369	0	444,789	1,489,445	2,198,824	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.095817	0.000000	0.312348	0.034926	0.060582	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: 14-0239

Period:
From 07/01/2019
To 06/30/2020

Worksheet B-1

Date/Time Prepared:
4/22/2021 7:56 am

Cost Center Description			MEDICAL RECORDS & LIBRARY (GROSS REVE NUE)	SOCIAL SERVICE (VISITS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALAR Y & FRINGES APPRV (ASSIGNED TIME)	
			16.00	17.00	19.00	20.00	21.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,361,999,312					16.00
17.00	01700	SOCIAL SERVICE	0	7,821				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
20.00	02000	NURSING SCHOOL	0	0		0		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0			100	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0				22.00
23.00	02300	PARAMDICAL ED PROGRAM XRAY	0	0				23.00
23.01	02301	PASTORAL EDUCATION PROGRAM	0	0				23.01
23.02	02302	PARAMED EDUC EMT PROGRAM	0	0				23.02
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	68,417,831	6,661	0	0	100	30.00
31.00	03100	INTENSIVE CARE UNIT	19,123,698	0	0	0	0	31.00
34.01	03401	NEONATAL INTENSIVE CARE	70,491,568	102	0	0	0	34.01
34.02	03402	PEDIATRIC INTENSIVE CARE	4,392,219	29	0	0	0	34.02
40.00	04000	SUBPROVIDER - IPF	4,834,900	972	0	0	0	40.00
43.00	04300	NURSERY	15,941,951	57	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	72,389,879	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	8,822,485	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	30,716,050	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	15,455,082	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	79,069,685	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	6,889,789	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	13,489,669	0	0	0	0	56.00
57.00	05700	CT SCAN	83,512,176	0	0	0	0	57.00
58.00	05800	MRI	28,796,053	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	153,730,845	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	33,330,991	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	35,229,023	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	10,374,872	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	36,048,562	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	12,261,215	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	178,125,585	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	73,111,173	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	194,092,311	0	0	0	0	73.00
73.01	07301	INJECTABLE DRUGS	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	1,862,298	0	0	0	0	74.00
76.00	03340	GI LAB	13,605,457	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09003	PAIN CENTER	10,311,424	0	0	0	0	90.01
90.02	09001	ANTENATAL TEST CENTER	15,933,319	0	0	0	0	90.02
90.03	09002	CHILD PSYCHIATRIC CLINIC	144,612	0	0	0	0	90.03
90.04	09004	SPECIAL SURGICAL SERVICES	3,083,418	0	0	0	0	90.04
90.05	09005	GENETIC SERVICES	370,555	0	0	0	0	90.05
90.06	09006	HBP	37,811	0	0	0	0	90.06
90.07	09007	MAIN	204,346	0	0	0	0	90.07
90.08	09008	RMB	113,249	0	0	0	0	90.08

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0239

Period:
From 07/01/2019
To 06/30/2020

Worksheet B-1

Date/Time Prepared:
4/22/2021 7:56 am

Cost Center Description			MEDICAL RECORDS & LIBRARY (GROSS REVE NUE)	SOCIAL SERVICE (VISITS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALAR Y & FRINGES APPRV (ASSIGNED TIME)	
			16.00	17.00	19.00	20.00	21.00	
90.09	09009	MULFORD	29,361	0	0	0	0	90.09
90.10	09010	ALPINE	24,979	0	0	0	0	90.10
90.11	09011	ROSCOE	32,712	0	0	0	0	90.11
90.12	09012	BYRON	7,262	0	0	0	0	90.12
90.13	09013	WINNEBAGO	17,888	0	0	0	0	90.13
90.14	09014	PERRYVILLE	138,046	0	0	0	0	90.14
90.15	09015	BELVIDERE	15,517	0	0	0	0	90.15
90.16	09016	SPRINGBROOK	36,283	0	0	0	0	90.16
90.17	09017	MCFARLAND	2,338	0	0	0	0	90.17
90.18	09018	CHERRYVALLEY	12,520	0	0	0	0	90.18
90.19	09019	KLECKNER	1	0	0	0	0	90.19
90.20	09020	GALLERIA	44,062	0	0	0	0	90.20
90.21	09021	RIVERSIDE MOB	34,010	0	0	0	0	90.21
90.22	09022	MULFORD-LENOX	6,802	0	0	0	0	90.22
91.00	09100	EMERGENCY	66,300,462	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	982,968	0	0	0	0	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,361,999,312	7,821	0	0	100	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.01	19301	BELOIT HEART STANDBY	0	0	0	0	0	193.01
194.00	07950	GUEST CENTER	0	0	0	0	0	194.00
194.01	07954	OTHER NONREIMBURSEABLE COST CENTER	0	0	0	0	0	194.01
194.02	07951	COMMUNITY SERVICES	0	0	0	0	0	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERSO	0	0	0	0	0	194.03
194.04	07952	AUXILIARY	0	0	0	0	0	194.04
194.05	07956	RETAIL PHARMACY	0	0	0	0	0	194.05
194.08	07955	DIALYSIS RENTED SPACE	0	0	0	0	0	194.08
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	5,263,108	365,482	0	0	2,104,533	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.003864	46.730853	0.000000	0.000000	21,045.330000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	359,192	26,737	0	0	141,018	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000264	3.418617	0.000000	0.000000	1,410.180000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)				0		206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)				0.000000		207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0239

Period:
From 07/01/2019
To 06/30/2020

Worksheet B-1

Date/Time Prepared:
4/22/2021 7:56 am

Cost Center Description		INTERNS & RESIDENTS	PARAMEDICAL ED PROGRAM XRAY (ASSIGNED TIME)	PASTORAL EDUCATION PROGRAM (ASSIGNED TIME)	PARAMED EDUC EMT PROGRAM (TIME SPENT)	
		SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)				
		22.00	23.00	23.01	23.02	
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
6.00	00600	MAINTENANCE & REPAIRS				6.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
12.00	01200	MAINTENANCE OF PERSONNEL				12.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS				19.00
20.00	02000	NURSING SCHOOL				20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	100			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	100			22.00
23.00	02300	PARAMEDICAL ED PROGRAM XRAY		100		23.00
23.01	02301	PASTORAL EDUCATION PROGRAM		32,516		23.01
23.02	02302	PARAMED EDUC EMT PROGRAM			640	23.02
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	100	0	17	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	31.00
34.01	03401	NEONATAL INTENSIVE CARE	0	0	34	34.01
34.02	03402	PEDIATRIC INTENSIVE CARE	0	0	0	34.02
40.00	04000	SUBPROVIDER - IPF	0	0	0	40.00
43.00	04300	NURSERY	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	89	50.00
51.00	05100	RECOVERY ROOM	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	17	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	100	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	57.00
58.00	05800	MRI	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	13	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	73.00
73.01	07301	INJECTABLE DRUGS	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	74.00
76.00	03340	GI LAB	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	90.00
90.01	09003	PAIN CENTER	0	0	0	90.01
90.02	09001	ANTENATAL TEST CENTER	0	0	0	90.02
90.03	09002	CHILD PSYCHIATRIC CLINIC	0	0	0	90.03
90.04	09004	SPECIAL SURGICAL SERVICES	0	0	0	90.04
90.05	09005	GENETIC SERVICES	0	0	0	90.05
90.06	09006	HBP	0	0	0	90.06
90.07	09007	MAIN	0	0	0	90.07
90.08	09008	RMB	0	0	0	90.08

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0239

Period:
From 07/01/2019
To 06/30/2020

Worksheet B-1

Date/Time Prepared:
4/22/2021 7:56 am

Cost Center Description			INTERNS & RESIDENTS	PARAMDICAL ED PROGRAM XRAY (ASSIGNED TIME)	PASTORAL EDUCATION PROGRAM (ASSIGNED TIME)	PARAMED EDUC EMT PROGRAM (TIME SPENT)		
			SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)					
			22.00	23.00	23.01	23.02		
90.09	09009	MULFORD	0	0	0	0		90.09
90.10	09010	ALPINE	0	0	0	0		90.10
90.11	09011	ROSCOE	0	0	0	0		90.11
90.12	09012	BYRON	0	0	0	0		90.12
90.13	09013	WINNEBAGO	0	0	0	0		90.13
90.14	09014	PERRYVILLE	0	0	0	0		90.14
90.15	09015	BELVIDERE	0	0	0	0		90.15
90.16	09016	SPRINGBROOK	0	0	0	0		90.16
90.17	09017	MCFARLAND	0	0	0	0		90.17
90.18	09018	CHERRYVALLEY	0	0	0	0		90.18
90.19	09019	KLECKNER	0	0	0	0		90.19
90.20	09020	GALLERIA	0	0	0	0		90.20
90.21	09021	RIVERSIDE MOB	0	0	0	0		90.21
90.22	09022	MULFORD-LENOX	0	0	0	0		90.22
91.00	09100	EMERGENCY	0	0	0	470		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0		95.00
99.10	09910	CORF	0	0	0	0		99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0		99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0		99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0		99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	100	100	32,516	640		118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
193.01	19301	BELOIT HEART STANDBY	0	0	0	0		193.01
194.00	07950	GUEST CENTER	0	0	0	0		194.00
194.01	07954	OTHER NONREIMBURSEABLE COST CENTER	0	0	0	0		194.01
194.02	07951	COMMUNITY SERVICES	0	0	0	0		194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERSO	0	0	0	0		194.03
194.04	07952	AUXILIARY	0	0	0	0		194.04
194.05	07956	RETAIL PHARMACY	0	0	0	0		194.05
194.08	07955	DIALYSIS RENTED SPACE	0	0	0	0		194.08
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)	4,944,408	429,253	234,046	1,618,943		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	49,444.080000	4,292.530000	7.197872	2,529.598437		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	331,115	37,334	17,619	332,271		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	3,311.150000	373.340000	0.541856	519.173438		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)		0	0	0		206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)		0.000000	0.000000	0.000000		207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0239

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
4/22/2021 7:56 am

			Title XVIII		Hospital		PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	
					Total Costs	RCE Disallowance		
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	43,821,111		43,821,111	0	43,821,111	30.00
31.00	03100	INTENSIVE CARE UNIT	9,556,262		9,556,262	0	9,556,262	31.00
34.01	03401	NEONATAL INTENSIVE CARE	15,190,471		15,190,471	0	15,190,471	34.01
34.02	03402	PEDIATRIC INTENSIVE CARE	2,011,617		2,011,617	0	2,011,617	34.02
40.00	04000	SUBPROVIDER - IPF	2,675,930		2,675,930	0	2,675,930	40.00
43.00	04300	NURSERY	5,720,799		5,720,799	0	5,720,799	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	22,544,676		22,544,676	0	22,544,676	50.00
51.00	05100	RECOVERY ROOM	2,185,624		2,185,624	0	2,185,624	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,237,282		8,237,282	0	8,237,282	52.00
53.00	05300	ANESTHESIOLOGY	1,344,701		1,344,701	0	1,344,701	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,509,482		14,509,482	0	14,509,482	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	3,302,609		3,302,609	0	3,302,609	55.00
56.00	05600	RADIOISOTOPE	1,106,398		1,106,398	0	1,106,398	56.00
57.00	05700	CT SCAN	3,342,416		3,342,416	0	3,342,416	57.00
58.00	05800	MRI	2,621,277		2,621,277	0	2,621,277	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	18,355,623		18,355,623	0	18,355,623	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0		0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	832,552		832,552	0	832,552	64.00
65.00	06500	RESPIRATORY THERAPY	5,933,749	0	5,933,749	0	5,933,749	65.00
66.00	06600	PHYSICAL THERAPY	3,042,164	0	3,042,164	0	3,042,164	66.00
69.00	06900	ELECTROCARDIOLOGY	3,384,797		3,384,797	0	3,384,797	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,516,850		1,516,850	0	1,516,850	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	27,583,822		27,583,822	0	27,583,822	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	15,617,042		15,617,042	0	15,617,042	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	40,828,056		40,828,056	0	40,828,056	73.00
73.01	07301	INJECTABLE DRUGS	0		0	0	0	73.01
74.00	07400	RENAL DIALYSIS	1,083,300		1,083,300	0	1,083,300	74.00
76.00	03340	GI LAB	2,849,597		2,849,597	0	2,849,597	76.00
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98
76.99	07699	LITHOTRIPSY	0		0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0		0	0	0	90.00
90.01	09003	PAIN CENTER	1,454,873		1,454,873	0	1,454,873	90.01
90.02	09001	ANTENATAL TEST CENTER	1,684,305		1,684,305	0	1,684,305	90.02
90.03	09002	CHILD PSYCHIATRIC CLINIC	220,894		220,894	0	220,894	90.03
90.04	09004	SPECIAL SURGICAL SERVICES	748,457		748,457	0	748,457	90.04
90.05	09005	GENETIC SERVICES	509,758		509,758	0	509,758	90.05
90.06	09006	HBP	146		146	0	146	90.06
90.07	09007	MAIN	790		790	0	790	90.07
90.08	09008	RMB	438		438	0	438	90.08
90.09	09009	MULFORD	653,351		653,351	0	653,351	90.09
90.10	09010	ALPINE	330,878		330,878	0	330,878	90.10
90.11	09011	ROSCOE	491,916		491,916	0	491,916	90.11
90.12	09012	BYRON	130,323		130,323	0	130,323	90.12
90.13	09013	WINNEBAGO	153,303		153,303	0	153,303	90.13
90.14	09014	PERRYVILLE	533		533	0	533	90.14
90.15	09015	BELVIDERE	60		60	0	60	90.15
90.16	09016	SPRINGBROOK	140		140	0	140	90.16
90.17	09017	MCFARLAND	9		9	0	9	90.17
90.18	09018	CHERRYVALLEY	124,611		124,611	0	124,611	90.18
90.19	09019	KLECKNER	0		0	0	0	90.19
90.20	09020	GALLERIA	160,806		160,806	0	160,806	90.20
90.21	09021	RIVERSIDE MOB	131		131	0	131	90.21
90.22	09022	MULFORD-LENOX	26		26	0	26	90.22
91.00	09100	EMERGENCY	17,880,567		17,880,567	11,512	17,892,079	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	7,402,417		7,402,417		7,402,417	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	1,647,930		1,647,930	0	1,647,930	95.00
99.10	09910	CORF	0		0		0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0		0		0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0		0		0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0		0		0	99.40
200.00		Subtotal (see instructions)	292,794,869	0	292,794,869	11,512	292,806,381	200.00
201.00		Less Observation Beds	7,402,417		7,402,417		7,402,417	201.00
202.00		Total (see instructions)	285,392,452	0	285,392,452	11,512	285,403,964	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0239

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
4/22/2021 7:56 am

			Title XVIII		Hospital	PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	66,633,286		66,633,286		30.00
31.00	03100	INTENSIVE CARE UNIT	25,660,411		25,660,411		31.00
34.01	03401	NEONATAL INTENSIVE CARE	78,158,027		78,158,027		34.01
34.02	03402	PEDIATRIC INTENSIVE CARE	5,259,202		5,259,202		34.02
40.00	04000	SUBPROVIDER - IPF	4,239,263		4,239,263		40.00
43.00	04300	NURSERY	7,350,622		7,350,622		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	37,007,928	43,449,304	80,457,232	0.280207	0.000000
51.00	05100	RECOVERY ROOM	3,756,625	4,990,204	8,746,829	0.249876	0.000000
52.00	05200	DELIVERY ROOM & LABOR ROOM	28,039,175	3,407,121	31,446,296	0.261948	0.000000
53.00	05300	ANESTHESIOLOGY	7,647,914	8,993,145	16,641,059	0.080806	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	44,038,828	45,560,314	89,599,142	0.161938	0.000000
55.00	05500	RADIOLOGY-THERAPEUTIC	167,017	16,269,751	16,436,768	0.200928	0.000000
56.00	05600	RADIOISOTOPE	2,308,849	12,247,142	14,555,991	0.076010	0.000000
57.00	05700	CT SCAN	32,777,564	66,025,412	98,802,976	0.033829	0.000000
58.00	05800	MRI	8,391,799	23,922,649	32,314,448	0.081118	0.000000
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000
60.00	06000	LABORATORY	78,446,631	83,006,996	161,453,627	0.113690	0.000000
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0.000000	0.000000
64.00	06400	INTRAVENOUS THERAPY	538,718	32,788,381	33,327,099	0.024981	0.000000
65.00	06500	RESPIRATORY THERAPY	36,851,760	2,454,818	39,306,578	0.150961	0.000000
66.00	06600	PHYSICAL THERAPY	9,201,530	3,201,436	12,402,966	0.245277	0.000000
69.00	06900	ELECTROCARDIOLOGY	15,099,663	25,344,149	40,443,812	0.083691	0.000000
70.00	07000	ELECTROENCEPHALOGRAPHY	2,257,859	9,676,030	11,933,889	0.127104	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	103,834,151	55,600,307	159,434,458	0.173010	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	49,327,029	30,049,998	79,377,027	0.196745	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	89,674,154	104,418,157	194,092,311	0.210354	0.000000
73.01	07301	INJECTABLE DRUGS	0	0	0	0.000000	0.000000
74.00	07400	RENAL DIALYSIS	1,670,878	109,500	1,780,378	0.068466	0.000000
76.00	03340	GI LAB	2,240,190	8,617,620	10,857,810	0.262447	0.000000
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0.000000	0.000000
90.01	09003	PAIN CENTER	12,378	8,212,725	8,225,103	0.176882	0.000000
90.02	09001	ANTENATAL TEST CENTER	486,372	16,538,936	17,025,308	0.098929	0.000000
90.03	09002	CHILD PSYCHIATRIC CLINIC	0	131,354	131,354	1.681669	0.000000
90.04	09004	SPECIAL SURGICAL SERVICES	34,047	2,807,929	2,841,976	0.263358	0.000000
90.05	09005	GENETIC SERVICES	2,622	283,068	285,690	1.784305	0.000000
90.06	09006	HBP	2,956	571,900	574,856	0.000254	0.000000
90.07	09007	MAIN	12,883	3,460,547	3,473,430	0.000227	0.000000
90.08	09008	RMB	2,618	1,271,679	1,274,297	0.000344	0.000000
90.09	09009	MULFORD	2,099	425,357	427,456	1.528464	0.000000
90.10	09010	ALPINE	1,992	461,915	463,907	0.713242	0.000000
90.11	09011	ROSCOE	2,412	442,783	445,195	1.104945	0.000000
90.12	09012	BYRON	984	140,834	141,818	0.918945	0.000000
90.13	09013	WINNEBAGO	2,093	337,117	339,210	0.451941	0.000000
90.14	09014	PERRYVILLE	8,287	2,211,746	2,220,033	0.000240	0.000000
90.15	09015	BELVIDERE	936	153,760	154,696	0.000388	0.000000
90.16	09016	SPRINGBROOK	0	747,072	747,072	0.000187	0.000000
90.17	09017	MCFARLAND	1,000	39,328	40,328	0.000223	0.000000
90.18	09018	CHERRYVALLEY	606	244,108	244,714	0.509211	0.000000
90.19	09019	KLECKNER	0	0	0	0.000000	0.000000
90.20	09020	GALLERIA	469	565,960	566,429	0.283894	0.000000
90.21	09021	RIVERSIDE MOB	2,153	513,070	515,223	0.000254	0.000000
90.22	09022	MULFORD-LENOX	0	83,129	83,129	0.000313	0.000000
91.00	09100	EMERGENCY	23,426,122	57,113,325	80,539,447	0.222010	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,132,280	15,449,890	17,582,170	0.421018	0.000000
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	147,895	376,753	524,648	3.141020	0.000000
99.10	09910	CORF	0	0	0		99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0		99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0		99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0		99.40
200.00		Subtotal (see instructions)	766,862,277	692,716,719	1,459,578,996		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	766,862,277	692,716,719	1,459,578,996		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0239

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
4/22/2021 7:56 am

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
34.01	03401	NEONATAL INTENSIVE CARE			34.01
34.02	03402	PEDIATRIC INTENSIVE CARE			34.02
40.00	04000	SUBPROVIDER - IPF			40.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.280207		50.00
51.00	05100	RECOVERY ROOM	0.249876		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.261948		52.00
53.00	05300	ANESTHESIOLOGY	0.080806		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.161938		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.200928		55.00
56.00	05600	RADIOISOTOPE	0.076010		56.00
57.00	05700	CT SCAN	0.033829		57.00
58.00	05800	MRI	0.081118		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.113690		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000		62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
64.00	06400	INTRAVENOUS THERAPY	0.024981		64.00
65.00	06500	RESPIRATORY THERAPY	0.150961		65.00
66.00	06600	PHYSICAL THERAPY	0.245277		66.00
69.00	06900	ELECTROCARDIOLOGY	0.083691		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.127104		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.173010		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.196745		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.210354		73.00
73.01	07301	INJECTABLE DRUGS	0.000000		73.01
74.00	07400	RENAL DIALYSIS	0.608466		74.00
76.00	03340	GI LAB	0.262447		76.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000		76.98
76.99	07699	LITHOTRIPSY	0.000000		76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.000000		90.00
90.01	09003	PAIN CENTER	0.176882		90.01
90.02	09001	ANTENATAL TEST CENTER	0.098929		90.02
90.03	09002	CHILD PSYCHIATRIC CLINIC	1.681669		90.03
90.04	09004	SPECIAL SURGICAL SERVICES	0.263358		90.04
90.05	09005	GENETIC SERVICES	1.784305		90.05
90.06	09006	HBP	0.000254		90.06
90.07	09007	MAIN	0.000227		90.07
90.08	09008	RMB	0.000344		90.08
90.09	09009	MULFORD	1.528464		90.09
90.10	09010	ALPINE	0.713242		90.10
90.11	09011	ROSCOE	1.104945		90.11
90.12	09012	BYRON	0.918945		90.12
90.13	09013	WINNEBAGO	0.451941		90.13
90.14	09014	PERRYVILLE	0.000240		90.14
90.15	09015	BELVIDERE	0.000388		90.15
90.16	09016	SPRINGBROOK	0.000187		90.16
90.17	09017	MCFARLAND	0.000223		90.17
90.18	09018	CHERRYVALLEY	0.509211		90.18
90.19	09019	KLECKNER	0.000000		90.19
90.20	09020	GALLERIA	0.283894		90.20
90.21	09021	RIVERSIDE MOB	0.000254		90.21
90.22	09022	MULFORD-LENOX	0.000313		90.22
91.00	09100	EMERGENCY	0.222153		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.421018		92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	3.141020		95.00
99.10	09910	CORF			99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY			99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY			99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY			99.40
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: 14-0239

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
4/22/2021 7:56 am

			Title XIX		Hospital		Cost
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		
					Total Costs	RCE Disallowance	Total Costs
			1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	50,870,052		50,870,052	0	0 30.00
31.00	03100	INTENSIVE CARE UNIT	9,556,262		9,556,262	0	0 31.00
34.01	03401	NEONATAL INTENSIVE CARE	15,190,471		15,190,471	0	0 34.01
34.02	03402	PEDIATRIC INTENSIVE CARE	2,011,617		2,011,617	0	0 34.02
40.00	04000	SUBPROVIDER - IPF	2,675,930		2,675,930	0	0 40.00
43.00	04300	NURSERY	5,720,799		5,720,799	0	0 43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	22,544,676		22,544,676	0	0 50.00
51.00	05100	RECOVERY ROOM	2,185,624		2,185,624	0	0 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,237,282		8,237,282	0	0 52.00
53.00	05300	ANESTHESIOLOGY	1,344,701		1,344,701	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,509,482		14,509,482	0	0 54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	3,302,609		3,302,609	0	0 55.00
56.00	05600	RADIOISOTOPE	1,106,398		1,106,398	0	0 56.00
57.00	05700	CT SCAN	3,342,416		3,342,416	0	0 57.00
58.00	05800	MRI	2,621,277		2,621,277	0	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0 59.00
60.00	06000	LABORATORY	18,355,623		18,355,623	0	0 60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0 62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0		0	0	0 63.00
64.00	06400	INTRAVENOUS THERAPY	832,552		832,552	0	0 64.00
65.00	06500	RESPIRATORY THERAPY	5,933,749	0	5,933,749	0	0 65.00
66.00	06600	PHYSICAL THERAPY	3,042,164	0	3,042,164	0	0 66.00
69.00	06900	ELECTROCARDIOLOGY	3,384,797		3,384,797	0	0 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,516,850		1,516,850	0	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	27,583,822		27,583,822	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	15,617,042		15,617,042	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	40,828,056		40,828,056	0	0 73.00
73.01	07301	INJECTABLE DRUGS	0		0	0	0 73.01
74.00	07400	RENAL DIALYSIS	1,083,300		1,083,300	0	0 74.00
76.00	03340	GI LAB	2,849,597		2,849,597	0	0 76.00
76.97	07697	CARDIAC REHABILITATION	0		0	0	0 76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0 76.98
76.99	07699	LITHOTRIPSY	0		0	0	0 76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0		0	0	0 90.00
90.01	09003	PAIN CENTER	1,454,873		1,454,873	0	0 90.01
90.02	09001	ANTENATAL TEST CENTER	1,684,305		1,684,305	0	0 90.02
90.03	09002	CHILD PSYCHIATRIC CLINIC	220,894		220,894	0	0 90.03
90.04	09004	SPECIAL SURGICAL SERVICES	748,457		748,457	0	0 90.04
90.05	09005	GENETIC SERVICES	509,758		509,758	0	0 90.05
90.06	09006	HBP	146		146	0	0 90.06
90.07	09007	MAIN	790		790	0	0 90.07
90.08	09008	RMB	438		438	0	0 90.08
90.09	09009	MULFORD	653,351		653,351	0	0 90.09
90.10	09010	ALPINE	330,878		330,878	0	0 90.10
90.11	09011	ROSCOE	491,916		491,916	0	0 90.11
90.12	09012	BYRON	130,323		130,323	0	0 90.12
90.13	09013	WINNEBAGO	153,303		153,303	0	0 90.13
90.14	09014	PERRYVILLE	533		533	0	0 90.14
90.15	09015	BELVIDERE	60		60	0	0 90.15
90.16	09016	SPRINGBROOK	140		140	0	0 90.16
90.17	09017	MCFARLAND	9		9	0	0 90.17
90.18	09018	CHERRYVALLEY	124,611		124,611	0	0 90.18
90.19	09019	KLECKNER	0		0	0	0 90.19
90.20	09020	GALLERIA	160,806		160,806	0	0 90.20
90.21	09021	RIVERSIDE MOB	131		131	0	0 90.21
90.22	09022	MULFORD-LENOX	26		26	0	0 90.22
91.00	09100	EMERGENCY	17,880,567		17,880,567	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	8,593,138		8,593,138	0	0 92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	1,647,930		1,647,930	0	0 95.00
99.10	09910	CORF	0		0	0	0 99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0		0	0	0 99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0		0	0	0 99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0		0	0	0 99.40
200.00		Subtotal (see instructions)	301,034,531	0	301,034,531	0	0 200.00
201.00		Less Observation Beds	8,593,138		8,593,138	0	0 201.00
202.00		Total (see instructions)	292,441,393	0	292,441,393	0	0 202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0239

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
4/22/2021 7:56 am

			Title XIX			Hospital		Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
			Inpatient	Outpatient	Total (col. 6 + col. 7)				
			6.00	7.00	8.00	9.00	10.00		
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0		0			30.00	
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00	
34.01	03401	NEONATAL INTENSIVE CARE	0		0			34.01	
34.02	03402	PEDIATRIC INTENSIVE CARE	0		0			34.02	
40.00	04000	SUBPROVIDER - IPF	0		0			40.00	
43.00	04300	NURSERY	0		0			43.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0.000000	0.000000	50.00	
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00	
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0.000000	0.000000	54.00	
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0.000000	0.000000	55.00	
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00	
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00	
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00	
60.00	06000	LABORATORY	0	0	0	0.000000	0.000000	60.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30	
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0.000000	0.000000	63.00	
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00	
65.00	06500	RESPIRATORY THERAPY	0	0	0	0.000000	0.000000	65.00	
66.00	06600	PHYSICAL THERAPY	0	0	0	0.000000	0.000000	66.00	
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0.000000	0.000000	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	73.00	
73.01	07301	INJECTABLE DRUGS	0	0	0	0.000000	0.000000	73.01	
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00	
76.00	03340	GI LAB	0	0	0	0.000000	0.000000	76.00	
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000	76.98	
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00	
90.01	09003	PAIN CENTER	0	0	0	0.000000	0.000000	90.01	
90.02	09001	ANTENATAL TEST CENTER	0	0	0	0.000000	0.000000	90.02	
90.03	09002	CHILD PSYCHIATRIC CLINIC	0	0	0	0.000000	0.000000	90.03	
90.04	09004	SPECIAL SURGICAL SERVICES	0	0	0	0.000000	0.000000	90.04	
90.05	09005	GENETIC SERVICES	0	0	0	0.000000	0.000000	90.05	
90.06	09006	HBP	0	0	0	0.000000	0.000000	90.06	
90.07	09007	MAIN	0	0	0	0.000000	0.000000	90.07	
90.08	09008	RMB	0	0	0	0.000000	0.000000	90.08	
90.09	09009	MULFORD	0	0	0	0.000000	0.000000	90.09	
90.10	09010	ALPINE	0	0	0	0.000000	0.000000	90.10	
90.11	09011	ROSCOE	0	0	0	0.000000	0.000000	90.11	
90.12	09012	BYRON	0	0	0	0.000000	0.000000	90.12	
90.13	09013	WINNEBAGO	0	0	0	0.000000	0.000000	90.13	
90.14	09014	PERRYVILLE	0	0	0	0.000000	0.000000	90.14	
90.15	09015	BELVIDERE	0	0	0	0.000000	0.000000	90.15	
90.16	09016	SPRINGBROOK	0	0	0	0.000000	0.000000	90.16	
90.17	09017	MCFARLAND	0	0	0	0.000000	0.000000	90.17	
90.18	09018	CHERRYVALLEY	0	0	0	0.000000	0.000000	90.18	
90.19	09019	KLECKNER	0	0	0	0.000000	0.000000	90.19	
90.20	09020	GALLERIA	0	0	0	0.000000	0.000000	90.20	
90.21	09021	RIVERSIDE MOB	0	0	0	0.000000	0.000000	90.21	
90.22	09022	MULFORD-LENOX	0	0	0	0.000000	0.000000	90.22	
91.00	09100	EMERGENCY	0	0	0	0.000000	0.000000	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0.000000	0.000000	92.00	
	OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00	
99.10	09910	CORF	0	0	0			99.10	
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0			99.20	
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0			99.30	
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0			99.40	
200.00		Subtotal (see instructions)	0	0	0			200.00	
201.00		Less Observation Beds						201.00	
202.00		Total (see instructions)	0	0	0			202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0239

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
4/22/2021 7:56 am

Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	Cost
			11.00			
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
34.01	03401	NEONATAL INTENSIVE CARE				34.01
34.02	03402	PEDIATRIC INTENSIVE CARE				34.02
40.00	04000	SUBPROVIDER - IPF				40.00
43.00	04300	NURSERY				43.00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.000000			50.00
51.00	05100	RECOVERY ROOM	0.000000			51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000			55.00
56.00	05600	RADIOISOTOPE	0.000000			56.00
57.00	05700	CT SCAN	0.000000			57.00
58.00	05800	MRI	0.000000			58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000			59.00
60.00	06000	LABORATORY	0.000000			60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000			62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000			63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000			64.00
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
73.01	07301	INJECTABLE DRUGS	0.000000			73.01
74.00	07400	RENAL DIALYSIS	0.000000			74.00
76.00	03340	GI LAB	0.000000			76.00
76.97	07697	CARDIAC REHABILITATION	0.000000			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000			76.98
76.99	07699	LITHOTRIPSY	0.000000			76.99
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.000000			90.00
90.01	09003	PAIN CENTER	0.000000			90.01
90.02	09001	ANTENATAL TEST CENTER	0.000000			90.02
90.03	09002	CHILD PSYCHIATRIC CLINIC	0.000000			90.03
90.04	09004	SPECIAL SURGICAL SERVICES	0.000000			90.04
90.05	09005	GENETIC SERVICES	0.000000			90.05
90.06	09006	HBP	0.000000			90.06
90.07	09007	MAIN	0.000000			90.07
90.08	09008	RMB	0.000000			90.08
90.09	09009	MULFORD	0.000000			90.09
90.10	09010	ALPINE	0.000000			90.10
90.11	09011	ROSCOE	0.000000			90.11
90.12	09012	BYRON	0.000000			90.12
90.13	09013	WINNEBAGO	0.000000			90.13
90.14	09014	PERRYVILLE	0.000000			90.14
90.15	09015	BELVIDERE	0.000000			90.15
90.16	09016	SPRINGBROOK	0.000000			90.16
90.17	09017	MCFARLAND	0.000000			90.17
90.18	09018	CHERRYVALLEY	0.000000			90.18
90.19	09019	KLECKNER	0.000000			90.19
90.20	09020	GALLERIA	0.000000			90.20
90.21	09021	RIVERSIDE MOB	0.000000			90.21
90.22	09022	MULFORD-LENOX	0.000000			90.22
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
	OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0.000000			95.00
99.10	09910	CORF				99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY				99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY				99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY				99.40
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0239

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part I
Date/Time Prepared:
4/22/2021 7:56 am

			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	4,239,830	0	4,239,830	49,703	85.30	30.00
31.00	INTENSIVE CARE UNIT	1,036,388		1,036,388	5,876	176.38	31.00
34.01	NEONATAL INTENSIVE CARE	1,589,488		1,589,488	13,823	114.99	34.01
34.02	PEDIATRIC INTENSIVE CARE	177,096		177,096	1,091	162.32	34.02
40.00	SUBPROVIDER - IPF	271,919	0	271,919	2,728	99.68	40.00
43.00	NURSERY	590,138		590,138	3,696	159.67	43.00
200.00	Total (lines 30 through 199)	7,904,859		7,904,859	76,917		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	13,390	1,142,167				30.00
31.00	INTENSIVE CARE UNIT	2,476	436,717				31.00
34.01	NEONATAL INTENSIVE CARE	0	0				34.01
34.02	PEDIATRIC INTENSIVE CARE	0	0				34.02
40.00	SUBPROVIDER - IPF	475	47,348				40.00
43.00	NURSERY	0	0				43.00
200.00	Total (lines 30 through 199)	16,341	1,626,232				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0239

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part II
Date/Time Prepared:
4/22/2021 7:56 am

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	4,281,116	80,457,232	0.053210	8,836,587	470,195	50.00
51.00	05100 RECOVERY ROOM	216,700	8,746,829	0.024775	1,080,340	26,765	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	867,850	31,446,296	0.027598	237,144	6,545	52.00
53.00	05300 ANESTHESIOLOGY	183,312	16,641,059	0.011016	1,700,910	18,737	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	3,611,850	89,599,142	0.040311	14,769,287	595,365	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	775,076	16,436,768	0.047155	35,084	1,654	55.00
56.00	05600 RADIOISOTOPE	281,869	14,555,991	0.019364	1,014,441	19,644	56.00
57.00	05700 CT SCAN	849,267	98,802,976	0.008596	11,822,537	101,627	57.00
58.00	05800 MRI	1,015,398	32,314,448	0.031422	2,701,216	84,878	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000 LABORATORY	2,156,703	161,453,627	0.013358	22,714,571	303,421	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	58,612	33,327,099	0.001759	143,455	252	64.00
65.00	06500 RESPIRATORY THERAPY	725,496	39,306,578	0.018457	8,607,370	158,866	65.00
66.00	06600 PHYSICAL THERAPY	218,324	12,402,966	0.017603	3,487,641	61,393	66.00
69.00	06900 ELECTROCARDIOLOGY	402,952	40,443,812	0.009963	5,277,804	52,583	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	284,360	11,933,889	0.023828	653,039	15,561	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2,339,846	159,434,458	0.014676	28,664,953	420,687	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1,326,568	79,377,027	0.016712	12,491,898	208,765	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	4,024,482	194,092,311	0.020735	24,694,381	512,038	73.00
73.01	07301 INJECTABLE DRUGS	0	0	0.000000	0	0	73.01
74.00	07400 RENAL DIALYSIS	81,187	1,780,378	0.045601	973,175	44,378	74.00
76.00	03340 GI LAB	1,096,550	10,857,810	0.100992	843,823	85,219	76.00
76.97	07697 CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699 LITHOTRIPSY	0	0	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0.000000	0	0	90.00
90.01	09003 PAIN CENTER	252,665	8,225,103	0.030719	9,436	290	90.01
90.02	09001 ANTENATAL TEST CENTER	265,054	17,025,308	0.015568	17,755	276	90.02
90.03	09002 CHILD PSYCHIATRIC CLINIC	16,171	131,354	0.123110	0	0	90.03
90.04	09004 SPECIAL SURGICAL SERVICES	130,772	2,841,976	0.046014	8,266	380	90.04
90.05	09005 GENETIC SERVICES	44,657	285,690	0.156313	0	0	90.05
90.06	09006 HBP	10	574,856	0.000017	2,842	0	90.06
90.07	09007 MAIN	54	3,473,430	0.000016	11,225	0	90.07
90.08	09008 RMB	30	1,274,297	0.000024	2,492	0	90.08
90.09	09009 MULFORD	121,625	427,456	0.284532	1,999	569	90.09
90.10	09010 ALPINE	61,590	463,907	0.132764	1,793	238	90.10
90.11	09011 ROSCOE	91,568	445,195	0.205681	2,039	419	90.11
90.12	09012 BYRON	24,260	141,818	0.171064	883	151	90.12
90.13	09013 WINNEBAGO	28,533	339,210	0.084116	1,995	168	90.13
90.14	09014 PERRYVILLE	36	2,220,033	0.000016	7,586	0	90.14
90.15	09015 BELVIDERE	4	154,696	0.000026	726	0	90.15
90.16	09016 SPRINGBROOK	10	747,072	0.000013	0	0	90.16
90.17	09017 MCFARLAND	1	40,328	0.000025	971	0	90.17
90.18	09018 CHERRYVALLEY	23,193	244,714	0.094776	547	52	90.18
90.19	09019 KLECKNER	0	0	0.000000	0	0	90.19
90.20	09020 GALLERIA	29,918	566,429	0.052819	451	24	90.20
90.21	09021 RIVERSIDE MOB	9	515,223	0.000017	2,054	0	90.21
90.22	09022 MULFORD-LENOX	2	83,129	0.000024	0	0	90.22
91.00	09100 EMERGENCY	1,880,966	80,539,447	0.023355	8,533,357	199,297	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	716,206	17,582,170	0.040735	1,168,283	47,590	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)	28,484,852	1,271,753,537		160,524,356	3,438,027	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0239		Period: From 07/01/2019 To 06/30/2020		Worksheet D Part III Date/Time Prepared: 4/22/2021 7:56 am		
					Title XVIII		Hospital		PPS		
Cost Center Description					Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost		
					1A	1.00	2A	2.00	3.00		
	INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS		0	0	0	190,718	0	30.00		
31.00	03100	INTENSIVE CARE UNIT		0	0	0	16,318	0	31.00		
34.01	03401	NEONATAL INTENSIVE CARE		0	0	0	128,725	0	34.01		
34.02	03402	PEDIATRIC INTENSIVE CARE		0	0	0	4,657	0	34.02		
40.00	04000	SUBPROVIDER - IPF		0	0	0	13,424	0	40.00		
43.00	04300	NURSERY		0	0	0	9,213	0	43.00		
200.00		Total (lines 30 through 199)		0	0	0	363,055	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	190,718	49,703	3.84	13,390	30.00		
31.00	03100	INTENSIVE CARE UNIT			16,318	5,876	2.78	2,476	31.00		
34.01	03401	NEONATAL INTENSIVE CARE			128,725	13,823	9.31	0	34.01		
34.02	03402	PEDIATRIC INTENSIVE CARE			4,657	1,091	4.27	0	34.02		
40.00	04000	SUBPROVIDER - IPF		0	13,424	2,728	4.92	475	40.00		
43.00	04300	NURSERY			9,213	3,696	2.49	0	43.00		
200.00		Total (lines 30 through 199)			363,055	76,917		16,341	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		51,418						30.00	
31.00	03100	INTENSIVE CARE UNIT		6,883						31.00	
34.01	03401	NEONATAL INTENSIVE CARE		0						34.01	
34.02	03402	PEDIATRIC INTENSIVE CARE		0						34.02	
40.00	04000	SUBPROVIDER - IPF		2,337						40.00	
43.00	04300	NURSERY		0						43.00	
200.00		Total (lines 30 through 199)		60,638						200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0239

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part IV
Date/Time Prepared:
4/22/2021 7:56 am

Cost Center Description		Title XVIII		Hospital		PPS	
		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	0	225,134	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	43,003	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	429,253	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600 RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MRI	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	32,885	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301 INJECTABLE DRUGS	0	0	0	0	0	73.01
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03340 GI LAB	0	0	0	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699 LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0	0	0	90.00
90.01	09003 PAIN CENTER	0	0	0	0	0	90.01
90.02	09001 ANTENATAL TEST CENTER	0	0	0	0	0	90.02
90.03	09002 CHILD PSYCHIATRIC CLINIC	0	0	0	0	0	90.03
90.04	09004 SPECIAL SURGICAL SERVICES	0	0	0	0	0	90.04
90.05	09005 GENETIC SERVICES	0	0	0	0	0	90.05
90.06	09006 HBP	0	0	0	0	0	90.06
90.07	09007 MAIN	0	0	0	0	0	90.07
90.08	09008 RMB	0	0	0	0	0	90.08
90.09	09009 MULFORD	0	0	0	0	0	90.09
90.10	09010 ALPINE	0	0	0	0	0	90.10
90.11	09011 ROSCOE	0	0	0	0	0	90.11
90.12	09012 BYRON	0	0	0	0	0	90.12
90.13	09013 WINNEBAGO	0	0	0	0	0	90.13
90.14	09014 PERRYVILLE	0	0	0	0	0	90.14
90.15	09015 BELVIDERE	0	0	0	0	0	90.15
90.16	09016 SPRINGBROOK	0	0	0	0	0	90.16
90.17	09017 MCFARLAND	0	0	0	0	0	90.17
90.18	09018 CHERRYVALLEY	0	0	0	0	0	90.18
90.19	09019 KLECKNER	0	0	0	0	0	90.19
90.20	09020 GALLERIA	0	0	0	0	0	90.20
90.21	09021 RIVERSIDE MOB	0	0	0	0	0	90.21
90.22	09022 MULFORD-LENOX	0	0	0	0	0	90.22
91.00	09100 EMERGENCY	0	0	0	0	1,188,912	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	32,215	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	0	0	0	0	0	95.00
200.00	Total (lines 50 through 199)	0	0	0	0	1,951,402	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0239

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part IV
Date/Time Prepared:
4/22/2021 7:56 am

Cost Center Description		All Other Medical Education Cost	Title XVIII		Hospital		Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			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)			
		4.00	5.00	6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000 OPERATING ROOM	0	225,134	225,134	80,457,232	0.002798		50.00
51.00	05100 RECOVERY ROOM	0	0	0	8,746,829	0.000000		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	43,003	43,003	31,446,296	0.001368		52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	16,641,059	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	429,253	429,253	89,599,142	0.004791		54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0	16,436,768	0.000000		55.00
56.00	05600 RADIOISOTOPE	0	0	0	14,555,991	0.000000		56.00
57.00	05700 CT SCAN	0	0	0	98,802,976	0.000000		57.00
58.00	05800 MRI	0	0	0	32,314,448	0.000000		58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0.000000		59.00
60.00	06000 LABORATORY	0	0	0	161,453,627	0.000000		60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000		62.30
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0.000000		63.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	33,327,099	0.000000		64.00
65.00	06500 RESPIRATORY THERAPY	0	32,885	32,885	39,306,578	0.000837		65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	12,402,966	0.000000		66.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	40,443,812	0.000000		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	11,933,889	0.000000		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	159,434,458	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	79,377,027	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	194,092,311	0.000000		73.00
73.01	07301 INJECTABLE DRUGS	0	0	0	0	0.000000		73.01
74.00	07400 RENAL DIALYSIS	0	0	0	1,780,378	0.000000		74.00
76.00	03340 GI LAB	0	0	0	10,857,810	0.000000		76.00
76.97	07697 CARDIAC REHABILITATION	0	0	0	0	0.000000		76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000		76.98
76.99	07699 LITHOTRIPSY	0	0	0	0	0.000000		76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000 CLINIC	0	0	0	0	0.000000		90.00
90.01	09003 PAIN CENTER	0	0	0	8,225,103	0.000000		90.01
90.02	09001 ANTENATAL TEST CENTER	0	0	0	17,025,308	0.000000		90.02
90.03	09002 CHILD PSYCHIATRIC CLINIC	0	0	0	131,354	0.000000		90.03
90.04	09004 SPECIAL SURGICAL SERVICES	0	0	0	2,841,976	0.000000		90.04
90.05	09005 GENETIC SERVICES	0	0	0	285,690	0.000000		90.05
90.06	09006 HBP	0	0	0	574,856	0.000000		90.06
90.07	09007 MAIN	0	0	0	3,473,430	0.000000		90.07
90.08	09008 RMB	0	0	0	1,274,297	0.000000		90.08
90.09	09009 MULFORD	0	0	0	427,456	0.000000		90.09
90.10	09010 ALPINE	0	0	0	463,907	0.000000		90.10
90.11	09011 ROSCOE	0	0	0	445,195	0.000000		90.11
90.12	09012 BYRON	0	0	0	141,818	0.000000		90.12
90.13	09013 WINNEBAGO	0	0	0	339,210	0.000000		90.13
90.14	09014 PERRYVILLE	0	0	0	2,220,033	0.000000		90.14
90.15	09015 BELVIDERE	0	0	0	154,696	0.000000		90.15
90.16	09016 SPRINGBROOK	0	0	0	747,072	0.000000		90.16
90.17	09017 MCFARLAND	0	0	0	40,328	0.000000		90.17
90.18	09018 CHERRYVALLEY	0	0	0	244,714	0.000000		90.18
90.19	09019 KLECKNER	0	0	0	0	0.000000		90.19
90.20	09020 GALLERIA	0	0	0	566,429	0.000000		90.20
90.21	09021 RIVERSIDE MOB	0	0	0	515,223	0.000000		90.21
90.22	09022 MULFORD-LENOX	0	0	0	83,129	0.000000		90.22
91.00	09100 EMERGENCY	0	1,188,912	1,188,912	80,539,447	0.014762		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	32,215	32,215	17,582,170	0.001832		92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500 AMBULANCE SERVICES							95.00
200.00	Total (lines 50 through 199)	0	1,951,402	1,951,402	1,271,753,537			200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0239		Period: From 07/01/2019 To 06/30/2020	Worksheet D Part IV Date/Time Prepared: 4/22/2021 7:56 am	
				Title XVIII		Hospital	PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)
				9.00	10.00	11.00	12.00	13.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.002798	8,836,587	24,725	6,612,706	18,502	50.00
51.00	05100	RECOVERY ROOM	0.000000	1,080,340	0	586,412	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.001368	237,144	324	8,798	12	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	1,700,910	0	1,328,607	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.004791	14,769,287	70,760	9,144,594	43,812	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	35,084	0	4,628,517	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	1,014,441	0	3,803,238	0	56.00
57.00	05700	CT SCAN	0.000000	11,822,537	0	13,557,239	0	57.00
58.00	05800	MRI	0.000000	2,701,216	0	3,986,619	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	22,714,571	0	7,694,024	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	143,455	0	4,963,199	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000837	8,607,370	7,204	592,258	496	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	3,487,641	0	32,666	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	5,277,804	0	5,379,317	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	653,039	0	1,366,225	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	28,664,953	0	10,865,305	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	12,491,898	0	5,631,527	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	24,694,381	0	33,431,143	0	73.00
73.01	07301	INJECTABLE DRUGS	0.000000	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0.000000	973,175	0	58,789	0	74.00
76.00	03340	GI LAB	0.000000	843,823	0	1,615,447	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09003	PAIN CENTER	0.000000	9,436	0	1,819,448	0	90.01
90.02	09001	ANTENATAL TEST CENTER	0.000000	17,755	0	86,748	0	90.02
90.03	09002	CHILD PSYCHIATRIC CLINIC	0.000000	0	0	0	0	90.03
90.04	09004	SPECIAL SURGICAL SERVICES	0.000000	8,266	0	907,097	0	90.04
90.05	09005	GENETIC SERVICES	0.000000	0	0	3,702	0	90.05
90.06	09006	HBP	0.000000	2,842	0	178,998	0	90.06
90.07	09007	MAIN	0.000000	11,225	0	1,015,286	0	90.07
90.08	09008	RMB	0.000000	2,492	0	350,004	0	90.08
90.09	09009	MULFORD	0.000000	1,999	0	138,697	0	90.09
90.10	09010	ALPINE	0.000000	1,793	0	142,008	0	90.10
90.11	09011	ROSCOE	0.000000	2,039	0	109,969	0	90.11
90.12	09012	BYRON	0.000000	883	0	48,038	0	90.12
90.13	09013	WINNEBAGO	0.000000	1,995	0	106,994	0	90.13
90.14	09014	PERRYVILLE	0.000000	7,586	0	687,587	0	90.14
90.15	09015	BELVIDERE	0.000000	726	0	47,665	0	90.15
90.16	09016	SPRINGBROOK	0.000000	0	0	185,343	0	90.16
90.17	09017	MCFARLAND	0.000000	971	0	14,314	0	90.17
90.18	09018	CHERRYVALLEY	0.000000	547	0	68,880	0	90.18
90.19	09019	KLECKNER	0.000000	0	0	0	0	90.19
90.20	09020	GALLERIA	0.000000	451	0	202,703	0	90.20
90.21	09021	RIVERSIDE MOB	0.000000	2,054	0	191,455	0	90.21
90.22	09022	MULFORD-LENOX	0.000000	0	0	20,744	0	90.22
91.00	09100	EMERGENCY	0.014762	8,533,357	125,969	7,034,686	103,846	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.001832	1,168,283	2,140	2,349,833	4,305	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		160,524,356	231,122	130,996,829	170,973	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0239

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part V
Date/Time Prepared:
4/22/2021 7:56 am

			Title XVIII		Hospital	PPS	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs PPS Services (see inst.)
			1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.280207	6,612,706	0	0	1,852,927
51.00	05100	RECOVERY ROOM	0.249876	586,412	0	0	146,530
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.261948	8,798	0	0	2,305
53.00	05300	ANESTHESIOLOGY	0.080806	1,328,607	0	0	107,359
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.161938	9,144,594	0	0	1,480,857
55.00	05500	RADIOLOGY-THERAPEUTIC	0.200928	4,628,517	0	0	929,999
56.00	05600	RADIOISOTOPE	0.076010	3,803,238	0	0	289,084
57.00	05700	CT SCAN	0.033829	13,557,239	0	0	458,628
58.00	05800	MRI	0.081118	3,986,619	0	0	323,387
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0
60.00	06000	LABORATORY	0.113690	7,694,024	0	0	874,734
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0
64.00	06400	INTRAVENOUS THERAPY	0.024981	4,963,199	0	0	123,986
65.00	06500	RESPIRATORY THERAPY	0.150961	592,258	0	0	89,408
66.00	06600	PHYSICAL THERAPY	0.245277	32,666	0	0	8,012
69.00	06900	ELECTROCARDIOLOGY	0.083691	5,379,317	0	0	450,200
70.00	07000	ELECTROENCEPHALOGRAPHY	0.127104	1,366,225	0	0	173,653
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.173010	10,865,305	0	0	1,879,806
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.196745	5,631,527	0	0	1,107,975
73.00	07300	DRUGS CHARGED TO PATIENTS	0.210354	33,431,143	4,756	718,715	7,032,375
73.01	07301	INJECTABLE DRUGS	0.000000	0	0	0	0
74.00	07400	RENAL DIALYSIS	0.608466	58,789	0	0	35,771
76.00	03340	GI LAB	0.262447	1,615,447	0	0	423,969
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0.000000	0	0	0	0
90.01	09003	PAIN CENTER	0.176882	1,819,448	0	0	321,828
90.02	09001	ANTENATAL TEST CENTER	0.098929	86,748	0	0	8,582
90.03	09002	CHILD PSYCHIATRIC CLINIC	1.681669	0	0	0	0
90.04	09004	SPECIAL SURGICAL SERVICES	0.263358	907,097	0	0	238,891
90.05	09005	GENETIC SERVICES	1.784305	3,702	0	0	6,605
90.06	09006	HBP	0.000254	178,998	0	0	45
90.07	09007	MAIN	0.000227	1,015,286	0	0	230
90.08	09008	RMB	0.000344	350,004	0	0	120
90.09	09009	MULFORD	1.528464	138,697	0	0	211,993
90.10	09010	ALPINE	0.713242	142,008	0	0	101,286
90.11	09011	ROSCOE	1.104945	109,969	0	0	121,510
90.12	09012	BYRON	0.918945	48,038	0	0	44,144
90.13	09013	WINNEBAGO	0.451941	106,994	0	0	48,355
90.14	09014	PERRYVILLE	0.000240	687,587	0	0	165
90.15	09015	BELVIDERE	0.000388	47,665	0	0	18
90.16	09016	SPRINGBROOK	0.000187	185,343	0	0	35
90.17	09017	MCFARLAND	0.000223	14,314	0	0	3
90.18	09018	CHERRYVALLEY	0.509211	68,880	0	0	35,074
90.19	09019	KLECKNER	0.000000	0	0	0	0
90.20	09020	GALLERIA	0.283894	202,703	0	0	57,546
90.21	09021	RIVERSIDE MOB	0.000254	191,455	0	0	49
90.22	09022	MULFORD-LENOX	0.000313	20,744	0	0	6
91.00	09100	EMERGENCY	0.222010	7,034,686	0	0	1,561,771
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.421018	2,349,833	0	0	989,322
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	3.141020	0	0	0	0
200.00		Subtotal (see instructions)		130,996,829	4,756	718,715	21,538,543
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	
202.00		Net Charges (line 200 - line 201)		130,996,829	4,756	718,715	21,538,543

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0239

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part V
Date/Time Prepared:
4/22/2021 7:56 am

			Title XVIII		Hospital	PPS
	Cost Center Description	Costs				
		Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
		6.00	7.00			
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0	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	
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0		55.00	
56.00	05600 RADIOISOTOPE	0	0		56.00	
57.00	05700 CT SCAN	0	0		57.00	
58.00	05800 MRI	0	0		58.00	
59.00	05900 CARDIAC CATHETERIZATION	0	0		59.00	
60.00	06000 LABORATORY	0	0		60.00	
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		63.00	
64.00	06400 INTRAVENOUS THERAPY	0	0		64.00	
65.00	06500 RESPIRATORY THERAPY	0	0		65.00	
66.00	06600 PHYSICAL THERAPY	0	0		66.00	
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	1,000	151,185		73.00	
73.01	07301 INJECTABLE DRUGS	0	0		73.01	
74.00	07400 RENAL DIALYSIS	0	0		74.00	
76.00	03340 GI LAB	0	0		76.00	
76.97	07697 CARDIAC REHABILITATION	0	0		76.97	
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0		76.98	
76.99	07699 LITHOTRIPSY	0	0		76.99	
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0	0		90.00	
90.01	09003 PAIN CENTER	0	0		90.01	
90.02	09001 ANTENATAL TEST CENTER	0	0		90.02	
90.03	09002 CHILD PSYCHIATRIC CLINIC	0	0		90.03	
90.04	09004 SPECIAL SURGICAL SERVICES	0	0		90.04	
90.05	09005 GENETIC SERVICES	0	0		90.05	
90.06	09006 HBP	0	0		90.06	
90.07	09007 MAIN	0	0		90.07	
90.08	09008 RMB	0	0		90.08	
90.09	09009 MULFORD	0	0		90.09	
90.10	09010 ALPINE	0	0		90.10	
90.11	09011 ROSCOE	0	0		90.11	
90.12	09012 BYRON	0	0		90.12	
90.13	09013 WINNEBAGO	0	0		90.13	
90.14	09014 PERRYVILLE	0	0		90.14	
90.15	09015 BELVIDERE	0	0		90.15	
90.16	09016 SPRINGBROOK	0	0		90.16	
90.17	09017 MCFARLAND	0	0		90.17	
90.18	09018 CHERRYVALLEY	0	0		90.18	
90.19	09019 KLECKNER	0	0		90.19	
90.20	09020 GALLERIA	0	0		90.20	
90.21	09021 RIVERSIDE MOB	0	0		90.21	
90.22	09022 MULFORD-LENOX	0	0		90.22	
91.00	09100 EMERGENCY	0	0		91.00	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00	
	OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES	0			95.00	
200.00	Subtotal (see instructions)	1,000	151,185		200.00	
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0			201.00	
202.00	Net Charges (line 200 - line 201)	1,000	151,185		202.00	

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0239

Period:

Worksheet D

Component CCN: 14-S239

From 07/01/2019

Part II

To 06/30/2020

Date/Time Prepared:

4/22/2021 7:56 am

Title XVIII				Subprovider - IPF	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	4,281,116	80,457,232	0.053210	971	52
51.00	05100 RECOVERY ROOM	216,700	8,746,829	0.024775	0	0
52.00	05200 DELIVERY ROOM & LABOR ROOM	867,850	31,446,296	0.027598	0	0
53.00	05300 ANESTHESIOLOGY	183,312	16,641,059	0.011016	0	0
54.00	05400 RADIOLOGY-DIAGNOSTIC	3,611,850	89,599,142	0.040311	10,204	411
55.00	05500 RADIOLOGY-THERAPEUTIC	775,076	16,436,768	0.047155	0	0
56.00	05600 RADIOISOTOPE	281,869	14,555,991	0.019364	7,081	137
57.00	05700 CT SCAN	849,267	98,802,976	0.008596	29,553	254
58.00	05800 MRI	1,015,398	32,314,448	0.031422	0	0
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000	0	0
60.00	06000 LABORATORY	2,156,703	161,453,627	0.013358	95,006	1,269
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000	0	0
64.00	06400 INTRAVENOUS THERAPY	58,612	33,327,099	0.001759	12,629	22
65.00	06500 RESPIRATORY THERAPY	725,496	39,306,578	0.018457	6,162	114
66.00	06600 PHYSICAL THERAPY	218,324	12,402,966	0.017603	8,276	146
69.00	06900 ELECTROCARDIOLOGY	402,952	40,443,812	0.009963	7,811	78
70.00	07000 ELECTROENCEPHALOGRAPHY	284,360	11,933,889	0.023828	0	0
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2,339,846	159,434,458	0.014676	5,984	88
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1,326,568	79,377,027	0.016712	0	0
73.00	07300 DRUGS CHARGED TO PATIENTS	4,024,482	194,092,311	0.020735	130,823	2,713
73.01	07301 INJECTABLE DRUGS	0	0	0.000000	0	0
74.00	07400 RENAL DIALYSIS	81,187	1,780,378	0.045601	0	0
76.00	03340 GI LAB	1,096,550	10,857,810	0.100992	0	0
76.97	07697 CARDIAC REHABILITATION	0	0	0.000000	0	0
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0
76.99	07699 LITHOTRIPSY	0	0	0.000000	0	0
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	0	0.000000	0	0
90.01	09003 PAIN CENTER	252,665	8,225,103	0.030719	0	0
90.02	09001 ANTENATAL TEST CENTER	265,054	17,025,308	0.015568	0	0
90.03	09002 CHILD PSYCHIATRIC CLINIC	16,171	131,354	0.123110	0	0
90.04	09004 SPECIAL SURGICAL SERVICES	130,772	2,841,976	0.046014	0	0
90.05	09005 GENETIC SERVICES	44,657	285,690	0.156313	0	0
90.06	09006 HBP	10	574,856	0.000017	0	0
90.07	09007 MAIN	54	3,473,430	0.000016	0	0
90.08	09008 RMB	30	1,274,297	0.000024	0	0
90.09	09009 MULFORD	121,625	427,456	0.284532	0	0
90.10	09010 ALPINE	61,590	463,907	0.132764	0	0
90.11	09011 ROSCOE	91,568	445,195	0.205681	0	0
90.12	09012 BYRON	24,260	141,818	0.171064	0	0
90.13	09013 WINNEBAGO	28,533	339,210	0.084116	0	0
90.14	09014 PERRYVILLE	36	2,220,033	0.000016	0	0
90.15	09015 BELVIDERE	4	154,696	0.000026	0	0
90.16	09016 SPRINGBROOK	10	747,072	0.000013	0	0
90.17	09017 MCFARLAND	1	40,328	0.000025	0	0
90.18	09018 CHERRYVALLEY	23,193	244,714	0.094776	0	0
90.19	09019 KLECKNER	0	0	0.000000	0	0
90.20	09020 GALLERIA	29,918	566,429	0.052819	0	0
90.21	09021 RIVERSIDE MOB	9	515,223	0.000017	0	0
90.22	09022 MULFORD-LENOX	2	83,129	0.000024	0	0
91.00	09100 EMERGENCY	1,880,966	80,539,447	0.023355	88,490	2,067
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	17,582,170	0.000000	0	0
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES					
200.00	Total (lines 50 through 199)	27,768,646	1,271,753,537		402,990	7,351

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0239 Component CCN: 14-S239		Period: From 07/01/2019 To 06/30/2020		Worksheet D Part IV Date/Time Prepared: 4/22/2021 7:56 am	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	225,134	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	43,003	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	429,253	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC		0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE		0	0	0	0	0	56.00
57.00	05700	CT SCAN		0	0	0	0	0	57.00
58.00	05800	MRI		0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	0	0	59.00
60.00	06000	LABORATORY		0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS		0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.		0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY		0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	0	32,885	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	0	73.00
73.01	07301	INJECTABLE DRUGS		0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS		0	0	0	0	0	74.00
76.00	03340	GI LAB		0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION		0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY		0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	0	0	90.00
90.01	09003	PAIN CENTER		0	0	0	0	0	90.01
90.02	09001	ANTENATAL TEST CENTER		0	0	0	0	0	90.02
90.03	09002	CHILD PSYCHIATRIC CLINIC		0	0	0	0	0	90.03
90.04	09004	SPECIAL SURGICAL SERVICES		0	0	0	0	0	90.04
90.05	09005	GENETIC SERVICES		0	0	0	0	0	90.05
90.06	09006	HBP		0	0	0	0	0	90.06
90.07	09007	MAIN		0	0	0	0	0	90.07
90.08	09008	RMB		0	0	0	0	0	90.08
90.09	09009	MULFORD		0	0	0	0	0	90.09
90.10	09010	ALPINE		0	0	0	0	0	90.10
90.11	09011	ROSCOE		0	0	0	0	0	90.11
90.12	09012	BYRON		0	0	0	0	0	90.12
90.13	09013	WINNEBAGO		0	0	0	0	0	90.13
90.14	09014	PERRYVILLE		0	0	0	0	0	90.14
90.15	09015	BELVIDERE		0	0	0	0	0	90.15
90.16	09016	SPRINGBROOK		0	0	0	0	0	90.16
90.17	09017	MCFARLAND		0	0	0	0	0	90.17
90.18	09018	CHERRYVALLEY		0	0	0	0	0	90.18
90.19	09019	KLECKNER		0	0	0	0	0	90.19
90.20	09020	GALLERIA		0	0	0	0	0	90.20
90.21	09021	RIVERSIDE MOB		0	0	0	0	0	90.21
90.22	09022	MULFORD-LENOX		0	0	0	0	0	90.22
91.00	09100	EMERGENCY		0	0	0	0	1,188,912	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES		0	0	0	0	0	95.00
200.00		Total (lines 50 through 199)		0	0	0	0	1,919,187	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0239 Component CCN: 14-S239		Period: From 07/01/2019 To 06/30/2020		Worksheet D Part IV Date/Time Prepared: 4/22/2021 7:56 am	
				Title XVIII		Subprovider - IPF		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		225,134	225,134	80,457,232	0.002798	50.00
51.00	05100	RECOVERY ROOM	0		0	0	8,746,829	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		43,003	43,003	31,446,296	0.001368	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	16,641,059	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		429,253	429,253	89,599,142	0.004791	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0		0	0	16,436,768	0.000000	55.00
56.00	05600	RADIOISOTOPE	0		0	0	14,555,991	0.000000	56.00
57.00	05700	CT SCAN	0		0	0	98,802,976	0.000000	57.00
58.00	05800	MRI	0		0	0	32,314,448	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0		0	0	161,453,627	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	0.000000	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0		0	0	0	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0		0	0	33,327,099	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0		32,885	32,885	39,306,578	0.000837	65.00
66.00	06600	PHYSICAL THERAPY	0		0	0	12,402,966	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	40,443,812	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	11,933,889	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		0	0	159,434,458	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	79,377,027	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		0	0	194,092,311	0.000000	73.00
73.01	07301	INJECTABLE DRUGS	0		0	0	0	0.000000	73.01
74.00	07400	RENAL DIALYSIS	0		0	0	1,780,378	0.000000	74.00
76.00	03340	GI LAB	0		0	0	10,857,810	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0		0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0		0	0	0	0.000000	90.00
90.01	09003	PAIN CENTER	0		0	0	8,225,103	0.000000	90.01
90.02	09001	ANTENATAL TEST CENTER	0		0	0	17,025,308	0.000000	90.02
90.03	09002	CHILD PSYCHIATRIC CLINIC	0		0	0	131,354	0.000000	90.03
90.04	09004	SPECIAL SURGICAL SERVICES	0		0	0	2,841,976	0.000000	90.04
90.05	09005	GENETIC SERVICES	0		0	0	285,690	0.000000	90.05
90.06	09006	HBP	0		0	0	574,856	0.000000	90.06
90.07	09007	MAIN	0		0	0	3,473,430	0.000000	90.07
90.08	09008	RMB	0		0	0	1,274,297	0.000000	90.08
90.09	09009	MULFORD	0		0	0	427,456	0.000000	90.09
90.10	09010	ALPINE	0		0	0	463,907	0.000000	90.10
90.11	09011	ROSCOE	0		0	0	445,195	0.000000	90.11
90.12	09012	BYRON	0		0	0	141,818	0.000000	90.12
90.13	09013	WINNEBAGO	0		0	0	339,210	0.000000	90.13
90.14	09014	PERRYVILLE	0		0	0	2,220,033	0.000000	90.14
90.15	09015	BELVIDERE	0		0	0	154,696	0.000000	90.15
90.16	09016	SPRINGBROOK	0		0	0	747,072	0.000000	90.16
90.17	09017	MCFARLAND	0		0	0	40,328	0.000000	90.17
90.18	09018	CHERRYVALLEY	0		0	0	244,714	0.000000	90.18
90.19	09019	KLECKNER	0		0	0	0	0.000000	90.19
90.20	09020	GALLERIA	0		0	0	566,429	0.000000	90.20
90.21	09021	RIVERSIDE MOB	0		0	0	515,223	0.000000	90.21
90.22	09022	MULFORD-LENOX	0		0	0	83,129	0.000000	90.22
91.00	09100	EMERGENCY	0		1,188,912	1,188,912	80,539,447	0.014762	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0	0	17,582,170	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES							95.00
200.00		Total (lines 50 through 199)	0		1,919,187	1,919,187	1,271,753,537		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0239

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part IV
Date/Time Prepared:
4/22/2021 7:56 am

Component CCN: 14-S239

Title XVIII

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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	0.002798	971	3	0	0	50.00
51.00	05100 RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.001368	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.004791	10,204	49	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
56.00	05600 RADIOISOTOPE	0.000000	7,081	0	0	0	56.00
57.00	05700 CT SCAN	0.000000	29,553	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	95,006	0	0	0	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	12,629	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.000837	6,162	5	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	8,276	0	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	7,811	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	5,984	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	130,823	0	267	0	73.00
73.01	07301 INJECTABLE DRUGS	0.000000	0	0	0	0	73.01
74.00	07400 RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00	03340 GI LAB	0.000000	0	0	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699 LITHOTRIPSY	0.000000	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
90.01	09003 PAIN CENTER	0.000000	0	0	0	0	90.01
90.02	09001 ANTENATAL TEST CENTER	0.000000	0	0	0	0	90.02
90.03	09002 CHILD PSYCHIATRIC CLINIC	0.000000	0	0	0	0	90.03
90.04	09004 SPECIAL SURGICAL SERVICES	0.000000	0	0	0	0	90.04
90.05	09005 GENETIC SERVICES	0.000000	0	0	0	0	90.05
90.06	09006 HBP	0.000000	0	0	0	0	90.06
90.07	09007 MAIN	0.000000	0	0	0	0	90.07
90.08	09008 RMB	0.000000	0	0	0	0	90.08
90.09	09009 MULFORD	0.000000	0	0	0	0	90.09
90.10	09010 ALPINE	0.000000	0	0	0	0	90.10
90.11	09011 ROSCOE	0.000000	0	0	0	0	90.11
90.12	09012 BYRON	0.000000	0	0	0	0	90.12
90.13	09013 WINNEBAGO	0.000000	0	0	0	0	90.13
90.14	09014 PERRYVILLE	0.000000	0	0	0	0	90.14
90.15	09015 BELVIDERE	0.000000	0	0	0	0	90.15
90.16	09016 SPRINGBROOK	0.000000	0	0	0	0	90.16
90.17	09017 MCFARLAND	0.000000	0	0	0	0	90.17
90.18	09018 CHERRYVALLEY	0.000000	0	0	0	0	90.18
90.19	09019 KLECKNER	0.000000	0	0	0	0	90.19
90.20	09020 GALLERIA	0.000000	0	0	0	0	90.20
90.21	09021 RIVERSIDE MOB	0.000000	0	0	0	0	90.21
90.22	09022 MULFORD-LENOX	0.000000	0	0	0	0	90.22
91.00	09100 EMERGENCY	0.014762	88,490	1,306	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)		402,990	1,363	267	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0239

Period:

Worksheet D

Component CCN: 14-S239

From 07/01/2019
To 06/30/2020Part V
Date/Time Prepared:
4/22/2021 7:56 am

Title XVIII

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Cost Center Description			Charges				IPF		Costs	
			Cost to Charge Ratio From Worksheet C, Part I, col. 9	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	0.280207	0	0	0	0	0	50.00	
51.00	05100	RECOVERY ROOM	0.249876	0	0	0	0	0	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.261948	0	0	0	0	0	52.00	
53.00	05300	ANESTHESIOLOGY	0.080806	0	0	0	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.161938	0	0	0	0	0	54.00	
55.00	05500	RADIOLOGY-THERAPEUTIC	0.200928	0	0	0	0	0	55.00	
56.00	05600	RADIOISOTOPE	0.076010	0	0	0	0	0	56.00	
57.00	05700	CT SCAN	0.033829	0	0	0	0	0	57.00	
58.00	05800	MRI	0.081118	0	0	0	0	0	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	0	59.00	
60.00	06000	LABORATORY	0.113690	0	0	0	0	0	60.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	0	62.30	
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	0	63.00	
64.00	06400	INTRAVENOUS THERAPY	0.024981	0	0	0	0	0	64.00	
65.00	06500	RESPIRATORY THERAPY	0.150961	0	0	0	0	0	65.00	
66.00	06600	PHYSICAL THERAPY	0.245277	0	0	0	0	0	66.00	
69.00	06900	ELECTROCARDIOLOGY	0.083691	0	0	0	0	0	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0.127104	0	0	0	0	0	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.173010	0	0	0	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.196745	0	0	0	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.210354	267	0	2,863	56	73.00		
73.01	07301	INJECTABLE DRUGS	0.000000	0	0	0	0	73.01		
74.00	07400	RENAL DIALYSIS	0.608466	0	0	0	0	74.00		
76.00	03340	GI LAB	0.262447	0	0	0	0	76.00		
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97		
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98		
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99		
OUTPATIENT SERVICE COST CENTERS										
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00		
90.01	09003	PAIN CENTER	0.176882	0	0	0	0	90.01		
90.02	09001	ANTENATAL TEST CENTER	0.098929	0	0	0	0	90.02		
90.03	09002	CHILD PSYCHIATRIC CLINIC	1.681669	0	0	0	0	90.03		
90.04	09004	SPECIAL SURGICAL SERVICES	0.263358	0	0	0	0	90.04		
90.05	09005	GENETIC SERVICES	1.784305	0	0	0	0	90.05		
90.06	09006	HBP	0.000254	0	0	0	0	90.06		
90.07	09007	MAIN	0.000227	0	0	0	0	90.07		
90.08	09008	RMB	0.000344	0	0	0	0	90.08		
90.09	09009	MULFORD	1.528464	0	0	0	0	90.09		
90.10	09010	ALPINE	0.713242	0	0	0	0	90.10		
90.11	09011	ROSCOE	1.104945	0	0	0	0	90.11		
90.12	09012	BYRON	0.918945	0	0	0	0	90.12		
90.13	09013	WINNEBAGO	0.451941	0	0	0	0	90.13		
90.14	09014	PERRYVILLE	0.000240	0	0	0	0	90.14		
90.15	09015	BELVIDERE	0.000388	0	0	0	0	90.15		
90.16	09016	SPRINGBROOK	0.000187	0	0	0	0	90.16		
90.17	09017	MCFARLAND	0.000223	0	0	0	0	90.17		
90.18	09018	CHERRYVALLEY	0.509211	0	0	0	0	90.18		
90.19	09019	KLECKNER	0.000000	0	0	0	0	90.19		
90.20	09020	GALLERIA	0.283894	0	0	0	0	90.20		
90.21	09021	RIVERSIDE MOB	0.000254	0	0	0	0	90.21		
90.22	09022	MULFORD-LENOX	0.000313	0	0	0	0	90.22		
91.00	09100	EMERGENCY	0.222010	0	0	0	0	91.00		
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.421018	0	0	0	0	92.00		
OTHER REIMBURSABLE COST CENTERS										
95.00	09500	AMBULANCE SERVICES	3.141020		0			95.00		
200.00		Subtotal (see instructions)		267	0	2,863	56	200.00		
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00		
202.00		Net Charges (line 200 - line 201)		267	0	2,863	56	202.00		

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0239

Period:

Worksheet D

Component CCN: 14-S239

From 07/01/2019
To 06/30/2020Part V
Date/Time Prepared:
4/22/2021 7:56 am

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		Cost Center Description	Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
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
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
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	602		73.00
73.01	07301	INJECTABLE DRUGS	0	0		73.01
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03340	GI LAB	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0		76.99
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09003	PAIN CENTER	0	0		90.01
90.02	09001	ANTENATAL TEST CENTER	0	0		90.02
90.03	09002	CHILD PSYCHIATRIC CLINIC	0	0		90.03
90.04	09004	SPECIAL SURGICAL SERVICES	0	0		90.04
90.05	09005	GENETIC SERVICES	0	0		90.05
90.06	09006	HBP	0	0		90.06
90.07	09007	MAIN	0	0		90.07
90.08	09008	RMB	0	0		90.08
90.09	09009	MULFORD	0	0		90.09
90.10	09010	ALPINE	0	0		90.10
90.11	09011	ROSCOE	0	0		90.11
90.12	09012	BYRON	0	0		90.12
90.13	09013	WINNEBAGO	0	0		90.13
90.14	09014	PERRYVILLE	0	0		90.14
90.15	09015	BELVIDERE	0	0		90.15
90.16	09016	SPRINGBROOK	0	0		90.16
90.17	09017	MCFARLAND	0	0		90.17
90.18	09018	CHERRYVALLEY	0	0		90.18
90.19	09019	KLECKNER	0	0		90.19
90.20	09020	GALLERIA	0	0		90.20
90.21	09021	RIVERSIDE MOB	0	0		90.21
90.22	09022	MULFORD-LENOX	0	0		90.22
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	0	602		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	602		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0239

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part I
Date/Time Prepared:
4/22/2021 7:56 am

			Title XIX		Hospital	Cost	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	4,239,830	0	4,239,830	49,703	85.30	30.00
31.00	INTENSIVE CARE UNIT	1,036,388		1,036,388	5,876	176.38	31.00
34.01	NEONATAL INTENSIVE CARE	1,589,488		1,589,488	13,823	114.99	34.01
34.02	PEDIATRIC INTENSIVE CARE	177,096		177,096	1,091	162.32	34.02
40.00	SUBPROVIDER - IPF	271,919	0	271,919	2,728	99.68	40.00
43.00	NURSERY	590,138		590,138	3,696	159.67	43.00
200.00	Total (lines 30 through 199)	7,904,859		7,904,859	76,917		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	4,269	364,146				30.00
31.00	INTENSIVE CARE UNIT	70	12,347				31.00
34.01	NEONATAL INTENSIVE CARE	3,140	361,069				34.01
34.02	PEDIATRIC INTENSIVE CARE	222	36,035				34.02
40.00	SUBPROVIDER - IPF	162	16,148				40.00
43.00	NURSERY	1,182	188,730				43.00
200.00	Total (lines 30 through 199)	9,045	978,475				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0239

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part II
Date/Time Prepared:
4/22/2021 7:56 am

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	4,281,116	0	0.000000	0	0	50.00
51.00	05100 RECOVERY ROOM	216,700	0	0.000000	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	867,850	0	0.000000	0	0	52.00
53.00	05300 ANESTHESIOLOGY	183,312	0	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	3,611,850	0	0.000000	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	775,076	0	0.000000	0	0	55.00
56.00	05600 RADIOISOTOPE	281,869	0	0.000000	0	0	56.00
57.00	05700 CT SCAN	849,267	0	0.000000	0	0	57.00
58.00	05800 MRI	1,015,398	0	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000 LABORATORY	2,156,703	0	0.000000	0	0	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	58,612	0	0.000000	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	725,496	0	0.000000	0	0	65.00
66.00	06600 PHYSICAL THERAPY	218,324	0	0.000000	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	402,952	0	0.000000	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	284,360	0	0.000000	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	2,339,846	0	0.000000	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1,326,568	0	0.000000	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	4,024,482	0	0.000000	0	0	73.00
73.01	07301 INJECTABLE DRUGS	0	0	0.000000	0	0	73.01
74.00	07400 RENAL DIALYSIS	81,187	0	0.000000	0	0	74.00
76.00	03340 GI LAB	1,096,550	0	0.000000	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699 LITHOTRIPSY	0	0	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0.000000	0	0	90.00
90.01	09003 PAIN CENTER	252,665	0	0.000000	0	0	90.01
90.02	09001 ANTENATAL TEST CENTER	265,054	0	0.000000	0	0	90.02
90.03	09002 CHILD PSYCHIATRIC CLINIC	16,171	0	0.000000	0	0	90.03
90.04	09004 SPECIAL SURGICAL SERVICES	130,772	0	0.000000	0	0	90.04
90.05	09005 GENETIC SERVICES	44,657	0	0.000000	0	0	90.05
90.06	09006 HBP	10	0	0.000000	0	0	90.06
90.07	09007 MAIN	54	0	0.000000	0	0	90.07
90.08	09008 RMB	30	0	0.000000	0	0	90.08
90.09	09009 MULFORD	121,625	0	0.000000	0	0	90.09
90.10	09010 ALPINE	61,590	0	0.000000	0	0	90.10
90.11	09011 ROSCOE	91,568	0	0.000000	0	0	90.11
90.12	09012 BYRON	24,260	0	0.000000	0	0	90.12
90.13	09013 WINNEBAGO	28,533	0	0.000000	0	0	90.13
90.14	09014 PERRYVILLE	36	0	0.000000	0	0	90.14
90.15	09015 BELVIDERE	4	0	0.000000	0	0	90.15
90.16	09016 SPRINGBROOK	10	0	0.000000	0	0	90.16
90.17	09017 MCFARLAND	1	0	0.000000	0	0	90.17
90.18	09018 CHERRYVALLEY	23,193	0	0.000000	0	0	90.18
90.19	09019 KLECKNER	0	0	0.000000	0	0	90.19
90.20	09020 GALLERIA	29,918	0	0.000000	0	0	90.20
90.21	09021 RIVERSIDE MOB	9	0	0.000000	0	0	90.21
90.22	09022 MULFORD-LENOX	2	0	0.000000	0	0	90.22
91.00	09100 EMERGENCY	1,880,966	0	0.000000	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	716,204	0	0.000000	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)	28,484,850	0		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0239		Period: From 07/01/2019 To 06/30/2020		Worksheet D Part III Date/Time Prepared: 4/22/2021 7:56 am	
					Title XIX		Hospital		Cost	
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	190,718	0	30.00		
31.00	03100	INTENSIVE CARE UNIT	0	0	0	16,318	0	31.00		
34.01	03401	NEONATAL INTENSIVE CARE	0	0	0	128,725	0	34.01		
34.02	03402	PEDIATRIC INTENSIVE CARE	0	0	0	4,657	0	34.02		
40.00	04000	SUBPROVIDER - IPF	0	0	0	13,424	0	40.00		
43.00	04300	NURSERY	0	0	0	9,213	0	43.00		
200.00		Total (lines 30 through 199)	0	0	0	363,055	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	190,718	49,703	3.84	4,269	30.00		
31.00	03100	INTENSIVE CARE UNIT		16,318	5,876	2.78	70	31.00		
34.01	03401	NEONATAL INTENSIVE CARE		128,725	13,823	9.31	3,140	34.01		
34.02	03402	PEDIATRIC INTENSIVE CARE		4,657	1,091	4.27	222	34.02		
40.00	04000	SUBPROVIDER - IPF	0	13,424	2,728	4.92	162	40.00		
43.00	04300	NURSERY		9,213	3,696	2.49	1,182	43.00		
200.00		Total (lines 30 through 199)		363,055	76,917		9,045	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	16,393						30.00	
31.00	03100	INTENSIVE CARE UNIT	195						31.00	
34.01	03401	NEONATAL INTENSIVE CARE	29,233						34.01	
34.02	03402	PEDIATRIC INTENSIVE CARE	948						34.02	
40.00	04000	SUBPROVIDER - IPF	797						40.00	
43.00	04300	NURSERY	2,943						43.00	
200.00		Total (lines 30 through 199)	50,509						200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0239

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part IV
Date/Time Prepared:
4/22/2021 7:56 am

Cost Center Description		Title XIX		Hospital		Cost	
		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	225,134	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	43,003	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	429,253	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
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
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	32,885	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	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
73.01	07301	INJECTABLE DRUGS	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03340	GI LAB	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09003	PAIN CENTER	0	0	0	0	90.01
90.02	09001	ANTENATAL TEST CENTER	0	0	0	0	90.02
90.03	09002	CHILD PSYCHIATRIC CLINIC	0	0	0	0	90.03
90.04	09004	SPECIAL SURGICAL SERVICES	0	0	0	0	90.04
90.05	09005	GENETIC SERVICES	0	0	0	0	90.05
90.06	09006	HBP	0	0	0	0	90.06
90.07	09007	MAIN	0	0	0	0	90.07
90.08	09008	RMB	0	0	0	0	90.08
90.09	09009	MULFORD	0	0	0	0	90.09
90.10	09010	ALPINE	0	0	0	0	90.10
90.11	09011	ROSCOE	0	0	0	0	90.11
90.12	09012	BYRON	0	0	0	0	90.12
90.13	09013	WINNEBAGO	0	0	0	0	90.13
90.14	09014	PERRYVILLE	0	0	0	0	90.14
90.15	09015	BELVIDERE	0	0	0	0	90.15
90.16	09016	SPRINGBROOK	0	0	0	0	90.16
90.17	09017	MCFARLAND	0	0	0	0	90.17
90.18	09018	CHERRYVALLEY	0	0	0	0	90.18
90.19	09019	KLECKNER	0	0	0	0	90.19
90.20	09020	GALLERIA	0	0	0	0	90.20
90.21	09021	RIVERSIDE MOB	0	0	0	0	90.21
90.22	09022	MULFORD-LENOX	0	0	0	0	90.22
91.00	09100	EMERGENCY	0	0	0	1,188,912	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	32,216	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	95.00
200.00		Total (lines 50 through 199)	0	0	0	1,951,403	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0239

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part IV
Date/Time Prepared:
4/22/2021 7:56 am

			Title XIX		Hospital	Cost		
	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	225,134	225,134	0	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	43,003	43,003	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	429,253	429,253	0	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MRI	0	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	0	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	32,885	32,885	0	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0.000000	73.00
73.01	07301	INJECTABLE DRUGS	0	0	0	0	0.000000	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0.000000	74.00
76.00	03340	GI LAB	0	0	0	0	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
90.01	09003	PAIN CENTER	0	0	0	0	0.000000	90.01
90.02	09001	ANTENATAL TEST CENTER	0	0	0	0	0.000000	90.02
90.03	09002	CHILD PSYCHIATRIC CLINIC	0	0	0	0	0.000000	90.03
90.04	09004	SPECIAL SURGICAL SERVICES	0	0	0	0	0.000000	90.04
90.05	09005	GENETIC SERVICES	0	0	0	0	0.000000	90.05
90.06	09006	HBP	0	0	0	0	0.000000	90.06
90.07	09007	MAIN	0	0	0	0	0.000000	90.07
90.08	09008	RMB	0	0	0	0	0.000000	90.08
90.09	09009	MULFORD	0	0	0	0	0.000000	90.09
90.10	09010	ALPINE	0	0	0	0	0.000000	90.10
90.11	09011	ROSCOE	0	0	0	0	0.000000	90.11
90.12	09012	BYRON	0	0	0	0	0.000000	90.12
90.13	09013	WINNEBAGO	0	0	0	0	0.000000	90.13
90.14	09014	PERRYVILLE	0	0	0	0	0.000000	90.14
90.15	09015	BELVIDERE	0	0	0	0	0.000000	90.15
90.16	09016	SPRINGBROOK	0	0	0	0	0.000000	90.16
90.17	09017	MCFARLAND	0	0	0	0	0.000000	90.17
90.18	09018	CHERRYVALLEY	0	0	0	0	0.000000	90.18
90.19	09019	KLECKNER	0	0	0	0	0.000000	90.19
90.20	09020	GALLERIA	0	0	0	0	0.000000	90.20
90.21	09021	RIVERSIDE MOB	0	0	0	0	0.000000	90.21
90.22	09022	MULFORD-LENOX	0	0	0	0	0.000000	90.22
91.00	09100	EMERGENCY	0	1,188,912	1,188,912	0	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	32,216	32,216	0	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0.000000	95.00
200.00		Total (lines 50 through 199)	0	1,951,403	1,951,403	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0239

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part IV
Date/Time Prepared:
4/22/2021 7:56 am

			Title XIX			Hospital	Cost	
	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	0.000000	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
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
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
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	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
73.01	07301	INJECTABLE DRUGS	0.000000	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00	03340	GI LAB	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09003	PAIN CENTER	0.000000	0	0	0	0	90.01
90.02	09001	ANTENATAL TEST CENTER	0.000000	0	0	0	0	90.02
90.03	09002	CHILD PSYCHIATRIC CLINIC	0.000000	0	0	0	0	90.03
90.04	09004	SPECIAL SURGICAL SERVICES	0.000000	0	0	0	0	90.04
90.05	09005	GENETIC SERVICES	0.000000	0	0	0	0	90.05
90.06	09006	HBP	0.000000	0	0	0	0	90.06
90.07	09007	MAIN	0.000000	0	0	0	0	90.07
90.08	09008	RMB	0.000000	0	0	0	0	90.08
90.09	09009	MULFORD	0.000000	0	0	0	0	90.09
90.10	09010	ALPINE	0.000000	0	0	0	0	90.10
90.11	09011	ROSCOE	0.000000	0	0	0	0	90.11
90.12	09012	BYRON	0.000000	0	0	0	0	90.12
90.13	09013	WINNEBAGO	0.000000	0	0	0	0	90.13
90.14	09014	PERRYVILLE	0.000000	0	0	0	0	90.14
90.15	09015	BELVIDERE	0.000000	0	0	0	0	90.15
90.16	09016	SPRINGBROOK	0.000000	0	0	0	0	90.16
90.17	09017	MCFARLAND	0.000000	0	0	0	0	90.17
90.18	09018	CHERRYVALLEY	0.000000	0	0	0	0	90.18
90.19	09019	KLECKNER	0.000000	0	0	0	0	90.19
90.20	09020	GALLERIA	0.000000	0	0	0	0	90.20
90.21	09021	RIVERSIDE MOB	0.000000	0	0	0	0	90.21
90.22	09022	MULFORD-LENOX	0.000000	0	0	0	0	90.22
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES		0	0	0	0	95.00
200.00		Total (lines 50 through 199)		0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0239 Component CCN: 14-S239		Period: From 07/01/2019 To 06/30/2020		Worksheet D Part IV Date/Time Prepared: 4/22/2021 7:56 am	
				Title XIX		Subprovider - IPF		Cost	
Cost Center Description				Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	225,134	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	43,003	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	429,253	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC		0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE		0	0	0	0	0	56.00
57.00	05700	CT SCAN		0	0	0	0	0	57.00
58.00	05800	MRI		0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	0	0	59.00
60.00	06000	LABORATORY		0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS		0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.		0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY		0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	0	32,885	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	0	73.00
73.01	07301	INJECTABLE DRUGS		0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS		0	0	0	0	0	74.00
76.00	03340	GI LAB		0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION		0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY		0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	0	0	90.00
90.01	09003	PAIN CENTER		0	0	0	0	0	90.01
90.02	09001	ANTENATAL TEST CENTER		0	0	0	0	0	90.02
90.03	09002	CHILD PSYCHIATRIC CLINIC		0	0	0	0	0	90.03
90.04	09004	SPECIAL SURGICAL SERVICES		0	0	0	0	0	90.04
90.05	09005	GENETIC SERVICES		0	0	0	0	0	90.05
90.06	09006	HBP		0	0	0	0	0	90.06
90.07	09007	MAIN		0	0	0	0	0	90.07
90.08	09008	RMB		0	0	0	0	0	90.08
90.09	09009	MULFORD		0	0	0	0	0	90.09
90.10	09010	ALPINE		0	0	0	0	0	90.10
90.11	09011	ROSCOE		0	0	0	0	0	90.11
90.12	09012	BYRON		0	0	0	0	0	90.12
90.13	09013	WINNEBAGO		0	0	0	0	0	90.13
90.14	09014	PERRYVILLE		0	0	0	0	0	90.14
90.15	09015	BELVIDERE		0	0	0	0	0	90.15
90.16	09016	SPRINGBROOK		0	0	0	0	0	90.16
90.17	09017	MCFARLAND		0	0	0	0	0	90.17
90.18	09018	CHERRYVALLEY		0	0	0	0	0	90.18
90.19	09019	KLECKNER		0	0	0	0	0	90.19
90.20	09020	GALLERIA		0	0	0	0	0	90.20
90.21	09021	RIVERSIDE MOB		0	0	0	0	0	90.21
90.22	09022	MULFORD-LENOX		0	0	0	0	0	90.22
91.00	09100	EMERGENCY		0	0	0	0	1,188,912	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES		0	0	0	0	0	95.00
200.00		Total (lines 50 through 199)		0	0	0	0	1,919,187	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0239 Component CCN: 14-S239		Period: From 07/01/2019 To 06/30/2020		Worksheet D Part IV Date/Time Prepared: 4/22/2021 7:56 am	
				Title XIX		Subprovider - IPF		Cost	
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		225,134	225,134	0	0.000000	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		43,003	43,003	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		429,253	429,253	0	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0		0	0	0	0.000000	55.00
56.00	05600	RADIOISOTOPE	0		0	0	0	0.000000	56.00
57.00	05700	CT SCAN	0		0	0	0	0.000000	57.00
58.00	05800	MRI	0		0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0		0	0	0	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	0.000000	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0		0	0	0	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0		0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0		32,885	32,885	0	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0		0	0	0	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		0	0	0	0.000000	73.00
73.01	07301	INJECTABLE DRUGS	0		0	0	0	0.000000	73.01
74.00	07400	RENAL DIALYSIS	0		0	0	0	0.000000	74.00
76.00	03340	GI LAB	0		0	0	0	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0		0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0		0	0	0	0.000000	90.00
90.01	09003	PAIN CENTER	0		0	0	0	0.000000	90.01
90.02	09001	ANTENATAL TEST CENTER	0		0	0	0	0.000000	90.02
90.03	09002	CHILD PSYCHIATRIC CLINIC	0		0	0	0	0.000000	90.03
90.04	09004	SPECIAL SURGICAL SERVICES	0		0	0	0	0.000000	90.04
90.05	09005	GENETIC SERVICES	0		0	0	0	0.000000	90.05
90.06	09006	HBP	0		0	0	0	0.000000	90.06
90.07	09007	MAIN	0		0	0	0	0.000000	90.07
90.08	09008	RMB	0		0	0	0	0.000000	90.08
90.09	09009	MULFORD	0		0	0	0	0.000000	90.09
90.10	09010	ALPINE	0		0	0	0	0.000000	90.10
90.11	09011	ROSCOE	0		0	0	0	0.000000	90.11
90.12	09012	BYRON	0		0	0	0	0.000000	90.12
90.13	09013	WINNEBAGO	0		0	0	0	0.000000	90.13
90.14	09014	PERRYVILLE	0		0	0	0	0.000000	90.14
90.15	09015	BELVIDERE	0		0	0	0	0.000000	90.15
90.16	09016	SPRINGBROOK	0		0	0	0	0.000000	90.16
90.17	09017	MCFARLAND	0		0	0	0	0.000000	90.17
90.18	09018	CHERRYVALLEY	0		0	0	0	0.000000	90.18
90.19	09019	KLECKNER	0		0	0	0	0.000000	90.19
90.20	09020	GALLERIA	0		0	0	0	0.000000	90.20
90.21	09021	RIVERSIDE MOB	0		0	0	0	0.000000	90.21
90.22	09022	MULFORD-LENOX	0		0	0	0	0.000000	90.22
91.00	09100	EMERGENCY	0		1,188,912	1,188,912	0	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0	0	0	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES							95.00
200.00		Total (lines 50 through 199)	0		1,919,187	1,919,187	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0239

Period:
From 07/01/2019
To 06/30/2020

Worksheet D
Part IV
Date/Time Prepared:
4/22/2021 7:56 am

Component CCN: 14-S239

				Title XIX		Subprovider - IPF		Cost	
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		0.000000	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
55.00	05500	RADIOLOGY-THERAPEUTIC		0.000000	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE		0.000000	0	0	0	0	56.00
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
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS		0.000000	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.		0.000000	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY		0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY		0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0.000000	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY		0.000000	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
73.01	07301	INJECTABLE DRUGS		0.000000	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS		0.000000	0	0	0	0	74.00
76.00	03340	GI LAB		0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION		0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY		0.000000	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0.000000	0	0	0	0	90.00
90.01	09003	PAIN CENTER		0.000000	0	0	0	0	90.01
90.02	09001	ANTENATAL TEST CENTER		0.000000	0	0	0	0	90.02
90.03	09002	CHILD PSYCHIATRIC CLINIC		0.000000	0	0	0	0	90.03
90.04	09004	SPECIAL SURGICAL SERVICES		0.000000	0	0	0	0	90.04
90.05	09005	GENETIC SERVICES		0.000000	0	0	0	0	90.05
90.06	09006	HBP		0.000000	0	0	0	0	90.06
90.07	09007	MAIN		0.000000	0	0	0	0	90.07
90.08	09008	RMB		0.000000	0	0	0	0	90.08
90.09	09009	MULFORD		0.000000	0	0	0	0	90.09
90.10	09010	ALPINE		0.000000	0	0	0	0	90.10
90.11	09011	ROSCOE		0.000000	0	0	0	0	90.11
90.12	09012	BYRON		0.000000	0	0	0	0	90.12
90.13	09013	WINNEBAGO		0.000000	0	0	0	0	90.13
90.14	09014	PERRYVILLE		0.000000	0	0	0	0	90.14
90.15	09015	BELVIDERE		0.000000	0	0	0	0	90.15
90.16	09016	SPRINGBROOK		0.000000	0	0	0	0	90.16
90.17	09017	MCFARLAND		0.000000	0	0	0	0	90.17
90.18	09018	CHERRYVALLEY		0.000000	0	0	0	0	90.18
90.19	09019	KLECKNER		0.000000	0	0	0	0	90.19
90.20	09020	GALLERIA		0.000000	0	0	0	0	90.20
90.21	09021	RIVERSIDE MOB		0.000000	0	0	0	0	90.21
90.22	09022	MULFORD-LENOX		0.000000	0	0	0	0	90.22
91.00	09100	EMERGENCY		0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0.000000	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES							95.00
200.00		Total (lines 50 through 199)			0	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0239	Period: From 07/01/2019 To 06/30/2020	Worksheet D-1 Date/Time Prepared: 4/22/2021 7:56 am
Cost Center Description		Title XVIII	Hospital	PPS
PART I - ALL PROVIDER COMPONENTS				1.00
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		49,703	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		49,703	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)		41,307	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)		13,390	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)		43,821,111	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)		43,821,111	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)		43,821,111	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)		881.66	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		11,805,427	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)		11,805,427	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0239

Period:
From 07/01/2019
To 06/30/2020

Worksheet D-1

Date/Time Prepared:
4/22/2021 7:56 am

		Title XVIII		Hospital	PPS	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	9,556,262	5,876	1,626.32	2,476	4,026,768
44.00	CORONARY CARE UNIT					
45.00	BURN INTENSIVE CARE UNIT					
46.00	SURGICAL INTENSIVE CARE UNIT					
46.01	NEONATAL INTENSIVE CARE	15,190,471	13,823	1,098.93	0	0
46.02	PEDIATRIC INTENSIVE CARE	2,011,617	1,091	1,843.83	0	0
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)					27,133,147
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					42,965,342
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					1,637,185
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					3,669,149
52.00	Total Program excludable cost (sum of lines 50 and 51)					5,306,334
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					37,659,008
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)					8,396
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					881.66
89.00	Observation bed cost (line 87 x line 88) (see instructions)					7,402,417

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0239

Period:
From 07/01/2019
To 06/30/2020

Worksheet D-1

Date/Time Prepared:
4/22/2021 7:56 am

Cost Center Description		Title XVIII		Hospital		PPS	
		Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	4,239,830	43,821,111	0.096753	7,402,417	716,206	90.00
91.00	Nursing School cost	0	43,821,111	0.000000	7,402,417	0	91.00
92.00	Allied health cost	190,718	43,821,111	0.004352	7,402,417	32,215	92.00
93.00	All other Medical Education	0	43,821,111	0.000000	7,402,417	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0239 Component CCN: 14-S239	Period: From 07/01/2019 To 06/30/2020	Worksheet D-1 Date/Time Prepared: 4/22/2021 7:56 am
		Title XVIII	Subprovider - IPF	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,728	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,728	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		2,728	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)		475	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)		2,675,930	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)		2,675,930	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)		2,675,930	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)		980.91	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		465,932	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)		465,932	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0239 Component CCN: 14-S239	Period: From 07/01/2019 To 06/30/2020	Worksheet D-1 Date/Time Prepared: 4/22/2021 7:56 am
			Title XVIII	Subprovider - IPF	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	0	0	0.00	0	0
44.00 CORONARY CARE UNIT					
45.00 BURN INTENSIVE CARE UNIT					
46.00 SURGICAL INTENSIVE CARE UNIT					
46.01 NEONATAL INTENSIVE CARE	0	0	0.00	0	0
46.02 PEDIATRIC INTENSIVE CARE	0	0	0.00	0	0
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)					66,404
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					532,336
PASS THROUGH COST ADJUSTMENTS					
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					49,685
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					8,714
52.00 Total Program excludable cost (sum of lines 50 and 51)					58,399
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					473,937
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)					0
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					0
72.00 Program routine service cost (line 9 x line 71)					0
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)					0
74.00 Total Program general inpatient routine service costs (line 72 + line 73)					0
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					0
76.00 Per diem capital-related costs (line 75 ÷ line 2)					0
77.00 Program capital-related costs (line 9 x line 76)					0
78.00 Inpatient routine service cost (line 74 minus line 77)					0
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)					0
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					0
81.00 Inpatient routine service cost per diem limitation					0
82.00 Inpatient routine service cost limitation (line 9 x line 81)					0
83.00 Reasonable inpatient routine service costs (see instructions)					0
84.00 Program inpatient ancillary services (see instructions)					0
85.00 Utilization review - physician compensation (see instructions)					0
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)					0
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00 Total observation bed days (see instructions)					0
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0239 Component CCN: 14-S239		Period: From 07/01/2019 To 06/30/2020		Worksheet D-1 Date/Time Prepared: 4/22/2021 7:56 am	
		Title XVIII		Subprovider - IPF		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	271,919	2,675,930	0.101617	0	0	90.00
91.00	Nursing School cost	0	2,675,930	0.000000	0	0	91.00
92.00	Allied health cost	13,424	2,675,930	0.005017	0	0	92.00
93.00	All other Medical Education	0	2,675,930	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0239	Period: From 07/01/2019 To 06/30/2020	Worksheet D-1 Date/Time Prepared: 4/22/2021 7:56 am	
		Title XIX	Hospital	Cost	
Cost Center Description				1.00	
	PART I - ALL PROVIDER COMPONENTS				
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		49,703	1.00	
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		49,703	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)		41,307	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)		4,269	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)		3,696	15.00	
16.00	Nursery days (title V or XIX only)		1,182	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)		50,870,052	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)		50,870,052	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)		50,870,052	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)		1,023.48	38.00	
39.00	Program general inpatient routine service cost (line 9 x line 38)		4,369,236	39.00	
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00	
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		4,369,236	41.00	

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0239

Period:
From 07/01/2019
To 06/30/2020

Worksheet D-1

Date/Time Prepared:
4/22/2021 7:56 am

Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
		1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)	5,720,799	3,696	1,547.84	1,182	1,829,547	42.00	
Intensive Care Type Inpatient Hospital Units								
43.00	INTENSIVE CARE UNIT	9,556,262	5,876	1,626.32	70	113,842	43.00	
44.00	CORONARY CARE UNIT						44.00	
45.00	BURN INTENSIVE CARE UNIT						45.00	
46.00	SURGICAL INTENSIVE CARE UNIT						46.00	
46.01	NEONATAL INTENSIVE CARE	15,190,471	13,823	1,098.93	3,140	3,450,640	46.01	
46.02	PEDIATRIC INTENSIVE CARE	2,011,617	1,091	1,843.83	222	409,330	46.02	
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)						10,172,595	49.00
PASS THROUGH COST ADJUSTMENTS								
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)						0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION								
54.00	Program discharges						0	54.00
55.00	Target amount per discharge						0.00	55.00
56.00	Target amount (line 54 x line 55)						0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0	57.00
58.00	Bonus payment (see instructions)						0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						0	61.00
62.00	Relief payment (see instructions)						0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)						0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST								
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY								
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)							70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00	Program routine service cost (line 9 x line 71)							72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00	Program capital-related costs (line 9 x line 76)							77.00
78.00	Inpatient routine service cost (line 74 minus line 77)							78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00	Inpatient routine service cost per diem limitation							81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00	Reasonable inpatient routine service costs (see instructions)							83.00
84.00	Program inpatient ancillary services (see instructions)							84.00
85.00	Utilization review - physician compensation (see instructions)							85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST								
87.00	Total observation bed days (see instructions)						8,396	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						1,023.48	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)						8,593,138	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0239

Period:
From 07/01/2019
To 06/30/2020

Worksheet D-1

Date/Time Prepared:
4/22/2021 7:56 am

		Title XIX		Hospital		Cost	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	4,239,830	50,870,052	0.083346	8,593,138	716,204	90.00
91.00	Nursing School cost	0	50,870,052	0.000000	8,593,138	0	91.00
92.00	Allied health cost	190,718	50,870,052	0.003749	8,593,138	32,216	92.00
93.00	All other Medical Education	0	50,870,052	0.000000	8,593,138	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0239 Component CCN: 14-S239	Period: From 07/01/2019 To 06/30/2020	Worksheet D-1 Date/Time Prepared: 4/22/2021 7:56 am
		Title XIX	Subprovider - IPF	Cost
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,728	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,728	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		2,728	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)		162	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)		3,696	15.00
16.00	Nursery days (title V or XIX only)		1,182	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)		2,675,930	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)		2,675,930	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)		2,675,930	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)		980.91	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		158,907	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)		158,907	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0239

Period:

Worksheet D-1

Component CCN: 14-S239

From 07/01/2019
To 06/30/2020Date/Time Prepared:
4/22/2021 7:56 am

		Title XIX		Subprovider - IPF		Cost	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	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						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
46.01	NEONATAL INTENSIVE CARE	0	0	0.00	0	0	46.01
46.02	PEDIATRIC INTENSIVE CARE	0	0	0.00	0	0	46.02
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)					158,907	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					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: 14-0239 Component CCN: 14-S239		Period: From 07/01/2019 To 06/30/2020		Worksheet D-1 Date/Time Prepared: 4/22/2021 7:56 am	
			Title XIX		Subprovider - IPF		Cost	
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	271,919	2,675,930	0.101617	0	0	90.00	
91.00	Nursing School cost	0	2,675,930	0.000000	0	0	91.00	
92.00	Allied health cost	13,424	2,675,930	0.005017	0	0	92.00	
93.00	All other Medical Education	0	2,675,930	0.000000	0	0	93.00	

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0239	Period: From 07/01/2019 To 06/30/2020	Worksheet D-3 Date/Time Prepared: 4/22/2021 7:56 am
Cost Center Description			Title XVIII	Hospital	PPS
			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
			1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		22,115,522	30.00
31.00	03100	INTENSIVE CARE UNIT		8,624,086	31.00
34.01	03401	NEONATAL INTENSIVE CARE		0	34.01
34.02	03402	PEDIATRIC INTENSIVE CARE		0	34.02
40.00	04000	SUBPROVIDER - IPF		0	40.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.280207	8,836,587	50.00
51.00	05100	RECOVERY ROOM	0.249876	1,080,340	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.261948	237,144	52.00
53.00	05300	ANESTHESIOLOGY	0.080806	1,700,910	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.161938	14,769,287	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.200928	35,084	55.00
56.00	05600	RADIOISOTOPE	0.076010	1,014,441	56.00
57.00	05700	CT SCAN	0.033829	11,822,537	57.00
58.00	05800	MRI	0.081118	2,701,216	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.113690	22,714,571	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.024981	143,455	64.00
65.00	06500	RESPIRATORY THERAPY	0.150961	8,607,370	65.00
66.00	06600	PHYSICAL THERAPY	0.245277	3,487,641	66.00
69.00	06900	ELECTROCARDIOLOGY	0.083691	5,277,804	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.127104	653,039	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.173010	28,664,953	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.196745	12,491,898	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.210354	24,694,381	73.00
73.01	07301	INJECTABLE DRUGS	0.000000	0	73.01
74.00	07400	RENAL DIALYSIS	0.608466	973,175	74.00
76.00	03340	GI LAB	0.262447	843,823	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.000000	0	90.00
90.01	09003	PAIN CENTER	0.176882	9,436	90.01
90.02	09001	ANTENATAL TEST CENTER	0.098929	17,755	90.02
90.03	09002	CHILD PSYCHIATRIC CLINIC	1.681669	0	90.03
90.04	09004	SPECIAL SURGICAL SERVICES	0.263358	8,266	90.04
90.05	09005	GENETIC SERVICES	1.784305	0	90.05
90.06	09006	HBP	0.000254	2,842	90.06
90.07	09007	MAIN	0.000227	11,225	90.07
90.08	09008	RMB	0.000344	2,492	90.08
90.09	09009	MULFORD	1.528464	1,999	90.09
90.10	09010	ALPINE	0.713242	1,793	90.10
90.11	09011	ROSCOE	1.104945	2,039	90.11
90.12	09012	BYRON	0.918945	883	90.12
90.13	09013	WINNEBAGO	0.451941	1,995	90.13
90.14	09014	PERRYVILLE	0.000240	7,586	90.14
90.15	09015	BELVIDERE	0.000388	726	90.15
90.16	09016	SPRINGBROOK	0.000187	0	90.16
90.17	09017	MCFARLAND	0.000223	971	90.17
90.18	09018	CHERRYVALLEY	0.509211	547	90.18
90.19	09019	KLECKNER	0.000000	0	90.19
90.20	09020	GALLERIA	0.283894	451	90.20
90.21	09021	RIVERSIDE MOB	0.000254	2,054	90.21
90.22	09022	MULFORD-LENOX	0.000313	0	90.22
91.00	09100	EMERGENCY	0.222153	8,533,357	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.421018	1,168,283	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		160,524,356	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)		160,524,356	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0239 Component CCN: 14-S239	Period: From 07/01/2019 To 06/30/2020	Worksheet D-3 Date/Time Prepared: 4/22/2021 7:56 am	
		Title XVIII	Subprovider - IPF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
34.01	03401 NEONATAL INTENSIVE CARE		0		34.01
34.02	03402 PEDIATRIC INTENSIVE CARE		0		34.02
40.00	04000 SUBPROVIDER - IPF		736,409		40.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.280207	971	272	50.00
51.00	05100 RECOVERY ROOM	0.249876	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.261948	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.080806	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.161938	10,204	1,652	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.200928	0	0	55.00
56.00	05600 RADIOISOTOPE	0.076010	7,081	538	56.00
57.00	05700 CT SCAN	0.033829	29,553	1,000	57.00
58.00	05800 MRI	0.081118	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000 LABORATORY	0.113690	95,006	10,801	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0.024981	12,629	315	64.00
65.00	06500 RESPIRATORY THERAPY	0.150961	6,162	930	65.00
66.00	06600 PHYSICAL THERAPY	0.245277	8,276	2,030	66.00
69.00	06900 ELECTROCARDIOLOGY	0.083691	7,811	654	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.127104	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.173010	5,984	1,035	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.196745	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.210354	130,823	27,519	73.00
73.01	07301 INJECTABLE DRUGS	0.000000	0	0	73.01
74.00	07400 RENAL DIALYSIS	0.608466	0	0	74.00
76.00	03340 GI LAB	0.262447	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699 LITHOTRIPSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.000000	0	0	90.00
90.01	09003 PAIN CENTER	0.176882	0	0	90.01
90.02	09001 ANTENATAL TEST CENTER	0.098929	0	0	90.02
90.03	09002 CHILD PSYCHIATRIC CLINIC	1.681669	0	0	90.03
90.04	09004 SPECIAL SURGICAL SERVICES	0.263358	0	0	90.04
90.05	09005 GENETIC SERVICES	1.784305	0	0	90.05
90.06	09006 HBP	0.000254	0	0	90.06
90.07	09007 MAIN	0.000227	0	0	90.07
90.08	09008 RMB	0.000344	0	0	90.08
90.09	09009 MULFORD	1.528464	0	0	90.09
90.10	09010 ALPINE	0.713242	0	0	90.10
90.11	09011 ROSCOE	1.104945	0	0	90.11
90.12	09012 BYRON	0.918945	0	0	90.12
90.13	09013 WINNEBAGO	0.451941	0	0	90.13
90.14	09014 PERRYVILLE	0.000240	0	0	90.14
90.15	09015 BELVIDERE	0.000388	0	0	90.15
90.16	09016 SPRINGBROOK	0.000187	0	0	90.16
90.17	09017 MCFARLAND	0.000223	0	0	90.17
90.18	09018 CHERRYVALLEY	0.509211	0	0	90.18
90.19	09019 KLECKNER	0.000000	0	0	90.19
90.20	09020 GALLERIA	0.283894	0	0	90.20
90.21	09021 RIVERSIDE MOB	0.000254	0	0	90.21
90.22	09022 MULFORD-LENOX	0.000313	0	0	90.22
91.00	09100 EMERGENCY	0.222153	88,490	19,658	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.421018	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		402,990	66,404	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		402,990		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0239

Period:
From 07/01/2019
To 06/30/2020Worksheet E
Part A
Date/Time Prepared:
4/22/2021 7:56 am

		Title XVIII	Hospital	PPS	
				1.00	
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS					
1.00	DRG Amounts Other than Outlier Payments			0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)			8,656,270	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)			23,311,801	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)			366,719	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)			570,219	2.04
3.00	Managed Care Simulated Payments			16,879,831	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)			282.24	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.			0.31	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.			0.39	14.00
15.00	Sum of lines 12 through 14 divided by 3.			0.23	15.00
16.00	Adjustment for residents in initial years of the program			24.75	16.00
17.00	Adjustment for residents displaced by program or hospital closure			0.00	17.00
18.00	Adjusted rolling average FTE count			24.98	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).			0.088506	19.00
20.00	Prior year resident to bed ratio (see instructions)			0.090177	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)			0.088506	21.00
22.00	IME payment adjustment (see instructions)			1,508,030	22.00
22.01	IME payment adjustment - Managed Care (see instructions)			796,272	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)			1,508,030	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			796,272	29.01
Disproportionate Share Adjustment					
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)			5.58	30.00
31.00	Percentage of Medicaid patient days (see instructions)			40.15	31.00
32.00	Sum of lines 30 and 31			45.73	32.00
33.00	Allowable disproportionate share percentage (see instructions)			26.94	33.00
34.00	Disproportionate share adjustment (see instructions)			2,153,050	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0239	Period: From 07/01/2019 To 06/30/2020	Worksheet E Part A Date/Time Prepared: 4/22/2021 7:56 am
		Title XVIII	Hospital	PPS
			Prior to 10/1	On/After 10/1
			1.00	2.00
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)		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)	2,803,812	1,164,955	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	706,715	872,125	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,578,840		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)				
40.00	Total Medicare discharges, excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	40.00
			Before 1/1	On/After 1/1
			1.00	1.01
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 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)	38,144,929		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)	0		48.00
			Amount	
			1.00	
49.00	Total payment for inpatient operating costs (see instructions)		38,941,201	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		2,993,773	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).		808,313	52.00
53.00	Nursing and Allied Health Managed Care payment		112,525	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).		58,301	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		231,122	58.00
59.00	Total (sum of amounts on lines 49 through 58)		43,145,235	59.00
60.00	Primary payer payments		14,694	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		43,130,541	61.00
62.00	Deductibles billed to program beneficiaries		3,051,004	62.00
63.00	Coinsurance billed to program beneficiaries		115,082	63.00
64.00	Allowable bad debts (see instructions)		1,323,610	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		860,347	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		1,005,129	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		40,824,802	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	MEDI/MEDI BAD DEBT RETROACTIVE ADJ		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)		-165,111	70.93
70.94	HRR adjustment amount (see instructions)		-102,761	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0239

Period:
From 07/01/2019
To 06/30/2020Worksheet E
Part A
Date/Time Prepared:
4/22/2021 7:56 am

		Title XVIII	Hospital	PPS	
		FFY (yyyy)	Amount		
		0	1.00		
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	0	70.97
70.98	Low Volume Payment-3			0	70.98
70.99	HAC adjustment amount (see instructions)			299,936	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)			40,256,994	71.00
71.01	Sequestration adjustment (see instructions)			672,292	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			36,256,077	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)			3,328,625	74.00
74.01	Balance due provider/program-PARHM (see instructions)			0	74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			1,272,843	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)			0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2			0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)			0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)			0	93.00
94.00	The rate used to calculate the time value of money (see instructions)			0.00	94.00
95.00	Time value of money for operating expenses (see instructions)			0	95.00
96.00	Time value of money for capital related expenses (see instructions)			0	96.00
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)		0	0	100.00
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)		0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	0	102.00
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)		0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	0	104.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)				201.00
202.00	Medicare discharges (see instructions)				202.00
203.00	Case-mix adjustment factor (see instructions)				203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
204.00	Medicare target amount				204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)				205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)				206.00
Adjustment to Medicare Part A Inpatient Reimbursement					
207.00	Program reimbursement under the \$410A Demonstration (see instructions)				207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)				208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)				211.00
Comparison of PPS versus Cost Reimbursement					
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)				212.00
213.00	Low-volume adjustment (see instructions)				213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)				218.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0239

Period:
From 07/01/2019
To 06/30/2020Worksheet E
Part A Exhibit 5
Date/Time Prepared:
4/22/2021 7:56 am

		Title XVIII		Hospital		PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	8,656,270	8,656,270		8,656,270	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	23,311,801		23,311,801	23,311,801	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	366,719	366,719		366,719	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	570,219		570,219	570,219	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	16,879,831	4,219,958	12,659,873	16,879,831	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.088506	0.088506	0.088506		5.00
6.00	IME payment adjustment (see instructions)	22.00	1,508,030	408,342	1,099,688	1,508,030	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	796,272	199,068	597,204	796,272	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	1,508,030	408,342	1,099,688	1,508,030	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	796,272	199,068	597,204	796,272	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.2694	0.2694	0.2694		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	2,153,050	583,000	1,570,050	2,153,050	11.00
11.01	Uncompensated care payments	36.00	1,578,840	706,715	872,125	1,578,840	11.01
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	38,144,929	10,721,046	27,423,883	38,144,929	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	38,941,201	10,920,114	28,021,087	38,941,201	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	2,993,773	824,382	2,169,391	2,993,773	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			11,744,496	30,190,478	41,934,974	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0239

Period:
From 07/01/2019
To 06/30/2020Worksheet E
Part A Exhibit 5
Date/Time Prepared:
4/22/2021 7:56 am

		Title XVIII		Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	2,549,310	703,547	1,845,763	2,549,310	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	93,678	24,027	69,651	93,678	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	0.0406	0.0406	0.0406		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	103,502	28,564	74,938	103,502	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0970	0.0970	0.0970		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	247,283	68,244	179,039	247,283	25.00
26.00	Total prospective capital payments (see instructions)	12.00	2,993,773	824,382	2,169,391	2,993,773	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	-165,111	-31,146	-133,965	-165,111	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	-102,761	-39,819	-62,942	-102,761	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	299,936	299,936	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0239	Period: From 07/01/2019 To 06/30/2020	Worksheet E Part B Date/Time Prepared: 4/22/2021 7:56 am
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		152,185	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		21,367,570	2.00
3.00	OPPS payments		20,087,659	3.00
4.00	Outlier payment (see instructions)		98,626	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		170,973	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		152,185	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		723,471	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)		723,471	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		723,471	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		571,286	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)		152,185	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)		20,357,258	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)		3,845,887	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)		16,663,556	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		403,068	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)		17,066,624	30.00
31.00	Primary payer payments		8,467	31.00
32.00	Subtotal (line 30 minus line 31)		17,058,157	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)		893,763	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		580,946	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		641,543	36.00
37.00	Subtotal (see instructions)		17,639,103	37.00
38.00	MSP-LCC reconciliation amount from PS&R		26	38.00
39.00	FORMULA DRIVEN OVERPAYMENT EST		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)		17,639,077	40.00
40.01	Sequestration adjustment (see instructions)		294,573	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		16,687,384	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)		657,120	43.00
43.01	Balance due provider/program-PARHM (see instructions)			43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)			93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0239 Component CCN: 14-S239	Period: From 07/01/2019 To 06/30/2020	Worksheet E Part B Date/Time Prepared: 4/22/2021 7:56 am
		Title XVIII	Subprovider - IPF	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		602	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		56	2.00
3.00	OPPS payments		225	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)		602	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		2,863	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)		2,863	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)		2,863	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		2,261	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)		602	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)		225	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)		827	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)		827	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		827	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)		827	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)		827	40.00
40.01	Sequestration adjustment (see instructions)		14	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		221	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)		592	43.00
43.01	Balance due provider/program-PARHM (see instructions)		0	43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0239

Period:
From 07/01/2019
To 06/30/2020Worksheet E-1
Part I
Date/Time Prepared:
4/22/2021 7:56 am

		Title XVIII		Hospital		PPS
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		36,318,177		16,787,884	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		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM	11/13/2019	62,100	11/13/2019	100,500	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)		-62,100		-100,500	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		36,256,077		16,687,384	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		3,328,625		657,120	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		39,584,702		17,344,504	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: 14-0239

Period:

Worksheet E-1

Component CCN: 14-S239

From 07/01/2019
To 06/30/2020Part I
Date/Time Prepared:
4/22/2021 7:56 am

Title XVIII

Subprovider -
IPF

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					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		340,365		221	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)		0		0	3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		340,365		221	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		4,147		592	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		344,512		813	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: 14-0239	Period: From 07/01/2019 To 06/30/2020	Worksheet E-1 Part II Date/Time Prepared: 4/22/2021 7:56 am
		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0239 Component CCN: 14-S239	Period: From 07/01/2019 To 06/30/2020	Worksheet E-3 Part II Date/Time Prepared: 4/22/2021 7:56 am
		Title XVIII	Subprovider - IPF	PPS
			1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS			
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)		417,392	1.00
2.00	Net IPF PPS Outlier Payments		0	2.00
3.00	Net IPF PPS ECT Payments		0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)		0.00	4.00
4.01	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	4.01
5.00	New Teaching program adjustment. (see instructions)		0.00	5.00
6.00	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	6.00
7.00	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	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)		0.00	8.00
9.00	Average Daily Census (see instructions)		7.453552	9.00
10.00	Teaching Adjustment Factor $\{((1 + (\text{line 8/line 9})) \text{ raised to the power of } .5150 - 1)\}$.		0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).		0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)		417,392	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)		0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)		0	14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)		0	15.00
16.00	Subtotal (see instructions)		417,392	16.00
17.00	Primary payer payments		0	17.00
18.00	Subtotal (line 16 less line 17).		417,392	18.00
19.00	Deductibles		69,036	19.00
20.00	Subtotal (line 18 minus line 19)		348,356	20.00
21.00	Coinurance		1,705	21.00
22.00	Subtotal (line 20 minus line 21)		346,651	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		18	23.00
24.00	Adjusted reimbursable bad debts (see instructions)		12	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	25.00
26.00	Subtotal (sum of lines 22 and 24)		346,663	26.00
27.00	Direct graduate medical education payments (see instructions)		0	27.00
28.00	Other pass through costs (see instructions)		3,700	28.00
29.00	Outlier payments reconciliation		0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	30.50
30.99	Demonstration payment adjustment amount before sequestration		0	30.99
31.00	Total amount payable to the provider (see instructions)		350,363	31.00
31.01	Sequestration adjustment (see instructions)		5,851	31.01
31.02	Demonstration payment adjustment amount after sequestration		0	31.02
32.00	Interim payments		340,365	32.00
33.00	Tentative settlement (for contractor use only)		0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)		4,147	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	35.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2		0	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)		0	51.00
52.00	The rate used to calculate the Time Value of Money		0.00	52.00
53.00	Time Value of Money (see instructions)		0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0239

Period:
From 07/01/2019
To 06/30/2020Worksheet E-3
Part VII
Date/Time Prepared:
4/22/2021 7:56 am

		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		10,172,595		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		10,172,595	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		10,172,595	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable Charges				
8.00	Routine service charges		0		8.00
9.00	Ancillary service charges		0	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		0	0	12.00
	CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		10,172,595	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		0	0	21.00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		0	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)		10,172,595	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	0	31.00
32.00	Deductibles		0	0	32.00
33.00	Coinurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40.00
41.00	Interim payments		0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0239 Component CCN: 14-S239	Period: From 07/01/2019 To 06/30/2020	Worksheet E-3 Part VII Date/Time Prepared: 4/22/2021 7:56 am
		Title XIX	Subprovider - IPF	Cost
		Inpatient 1.00	Outpatient 2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services	158,907		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	158,907	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	158,907	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	0	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	0	0	12.00
CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	158,907	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0	0	24.00
25.00	Capital exception payments (see instructions)	0	0	25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)	158,907	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0239		Period: From 07/01/2019 To 06/30/2020		Worksheet E-4 Date/Time Prepared: 4/22/2021 7:56 am	
		Title XVIII		Hospital		PPS	
						1.00	
COMPUTATION OF TOTAL DIRECT GME AMOUNT							
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.					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)					24.75	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.	24.75		0.00		24.75	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)	0.31		0.00			12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.39		0.00			13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	0.23		0.00			14.00
15.00	Adjustment for residents in initial years of new programs	24.75		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	24.98		0.00			17.00
18.00	Per resident amount	129,801.23		123,366.07			18.00
19.00	Approved amount for resident costs	3,242,435		0		3,242,435	19.00
						1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)					0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)					24.75	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)					3,242,435	25.00
		Inpatient Part A		Managed Care Prior to 1/1		Managed Care On or after 1/1	
		1.00		2.00		2.01	
						3.00	
COMPUTATION OF PROGRAM PATIENT LOAD							
26.00	Inpatient Days (see instructions) (Title XIX - see S-2 Part IX, line 3.02, column 2)	16,341		5,001		4,574	26.00
27.00	Total Inpatient Days (see instructions)	67,574		67,574		67,574	27.00
28.00	Ratio of inpatient days to total inpatient days	0.241824		0.074008		0.067689	28.00
29.00	Program direct GME amount	784,099		239,966		219,477	29.00
29.01	Percent reduction for MA DGME			7.00		7.00	29.01
30.00	Reduction for direct GME payments for Medicare Advantage			16,798		15,363	30.00
31.00	Net Program direct GME amount					1,211,381	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0239	Period: From 07/01/2019 To 06/30/2020	Worksheet E-4 Date/Time Prepared: 4/22/2021 7:56 am	
		Title XVIII	Hospital	PPS	
			1.00		
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)		0		32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)		1,780,378		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)		43,497,678		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)		14,694		40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)		43,482,984		41.00
Part B Reasonable Cost					
42.00	Reasonable cost (see instructions)		21,691,386		42.00
43.00	Primary payer payments (see instructions)		8,467		43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)		21,682,919		44.00
45.00	Total reasonable cost (sum of lines 41 and 44)		65,165,903		45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)		0.667266		46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)		0.332734		47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B					
48.00	Total program GME payment (line 31)		1,211,381		48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)		808,313		49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)		403,068		50.00

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

Provider CCN: 14-0239

Period:
From 07/01/2019
To 06/30/2020

Worksheet G

Date/Time Prepared:
4/22/2021 7:56 am

	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	1.00	2.00	3.00	4.00	
CURRENT ASSETS					
1.00 Cash on hand in banks	16,862,759	0	0	0	1.00
2.00 Temporary investments	0	0	0	0	2.00
3.00 Notes receivable	0	0	0	0	3.00
4.00 Accounts receivable	73,882,223	0	0	0	4.00
5.00 Other receivable	4,397,813	0	0	0	5.00
6.00 Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00 Inventory	11,892,356	0	0	0	7.00
8.00 Prepaid expenses	2,337,631	0	0	0	8.00
9.00 Other current assets	0	0	0	0	9.00
10.00 Due from other funds	873,790	0	0	0	10.00
11.00 Total current assets (sum of lines 1-10)	110,246,572	0	0	0	11.00
FIXED ASSETS					
12.00 Land	8,374,625	0	0	0	12.00
13.00 Land improvements	12,096,922	0	0	0	13.00
14.00 Accumulated depreciation	-7,630,681	0	0	0	14.00
15.00 Buildings	413,450,992	0	0	0	15.00
16.00 Accumulated depreciation	-58,453,724	0	0	0	16.00
17.00 Leasehold improvements	263,280	0	0	0	17.00
18.00 Accumulated depreciation	-140,115	0	0	0	18.00
19.00 Fixed equipment	169,932,431	0	0	0	19.00
20.00 Accumulated depreciation	-115,032,635	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	246,620,740	0	0	0	23.00
24.00 Accumulated depreciation	-166,582,819	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)	502,899,016	0	0	0	30.00
OTHER ASSETS					
31.00 Investments	136,134,533	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	16,519,632	0	0	0	34.00
35.00 Total other assets (sum of lines 31-34)	152,654,165	0	0	0	35.00
36.00 Total assets (sum of lines 11, 30, and 35)	765,799,753	0	0	0	36.00
CURRENT LIABILITIES					
37.00 Accounts payable	29,840,523	0	0	0	37.00
38.00 Salaries, wages, and fees payable	28,476,717	0	0	0	38.00
39.00 Payroll taxes payable	0	0	0	0	39.00
40.00 Notes and loans payable (short term)	0	0	0	0	40.00
41.00 Deferred income	11,084,578	0	0	0	41.00
42.00 Accelerated payments	0	0	0	0	42.00
43.00 Due to other funds	0	0	0	0	43.00
44.00 Other current liabilities	16,418,335	0	0	0	44.00
45.00 Total current liabilities (sum of lines 37 thru 44)	85,820,153	0	0	0	45.00
LONG TERM LIABILITIES					
46.00 Mortgage payable	0	0	0	0	46.00
47.00 Notes payable	460,615,000	0	0	0	47.00
48.00 Unsecured loans	0	0	0	0	48.00
49.00 Other long term liabilities	86,137,673	0	0	0	49.00
50.00 Total long term liabilities (sum of lines 46 thru 49)	546,752,673	0	0	0	50.00
51.00 Total liabilities (sum of lines 45 and 50)	632,572,826	0	0	0	51.00
CAPITAL ACCOUNTS					
52.00 General fund balance	133,226,927	0	0	0	52.00
53.00 Specific purpose fund	0	0	0	0	53.00
54.00 Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00 Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00 Governing body created - endowment fund balance	0	0	0	0	56.00
57.00 Plant fund balance - invested in plant	0	0	0	0	57.00
58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00 Total fund balances (sum of lines 52 thru 58)	133,226,927	0	0	0	59.00
60.00 Total liabilities and fund balances (sum of lines 51 and 59)	765,799,753	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0239

Period:
From 07/01/2019
To 06/30/2020

Worksheet G-1

Date/Time Prepared:
4/22/2021 7:56 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		192,989,590		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		29,006,327				2.00
3.00	Total (sum of line 1 and line 2)		221,995,917		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00	FAS 133 VALUATION CHANGE	0		0		0	5.00
6.00	RESTRICTED ASSETS CHANGE	0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		221,995,917		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00	TRANSFERS	88,768,989		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00	OTHER	0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		88,768,989		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		133,226,928		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	Additions (credit adjustments) (specify)		0				4.00
5.00	FAS 133 VALUATION CHANGE		0				5.00
6.00	RESTRICTED ASSETS CHANGE		0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00	TRANSFERS		0				13.00
14.00			0				14.00
15.00			0				15.00
16.00	OTHER		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: 14-0239

Period:
From 07/01/2019
To 06/30/2020Worksheet G-2
Parts I & II
Date/Time Prepared:
4/22/2021 7:56 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	82,073,349		82,073,349	1.00
2.00	SUBPROVIDER - IPF	4,261,630		4,261,630	2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	86,334,979		86,334,979	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	30,195,914		30,195,914	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
14.01	NEONATAL INTENSIVE CARE	95,618,888		95,618,888	14.01
14.02	PEDIATRIC INTENSIVE CARE	5,670,447		5,670,447	14.02
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	131,485,249		131,485,249	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	217,820,228		217,820,228	17.00
18.00	Ancillary services	546,670,109	0	546,670,109	18.00
19.00	Outpatient services	0	695,175,913	695,175,913	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
24.20	OUTPATIENT PHYSICAL THERAPY	0	0	0	24.20
24.30	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	24.30
24.40	OUTPATIENT SPEECH PATHOLOGY	0	0	0	24.40
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHARM	0	3,019,579	3,019,579	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	764,490,337	698,195,492	1,462,685,829	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		384,552,001		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00	BAD DEBTS	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	PHYSICIAN PRACTICE REVENUE	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)		384,552,001		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0239

Period:
From 07/01/2019
To 06/30/2020

Worksheet G-3

Date/Time Prepared:
4/22/2021 7:56 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	1,462,685,829	1.00
2.00	Less contractual allowances and discounts on patients' accounts	1,122,628,411	2.00
3.00	Net patient revenues (line 1 minus line 2)	340,057,418	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	384,552,001	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-44,494,583	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	OTHER OPERATING INCOME	56,620,615	24.00
24.01	OTHER NON-OPERATING INCOME	6,824,801	24.01
24.02	PROVIDER TAX	0	24.02
24.50	COVID-19 PHE Funding	10,055,494	24.50
25.00	Total other income (sum of lines 6-24)	73,500,910	25.00
26.00	Total (line 5 plus line 25)	29,006,327	26.00
27.00	MISC	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	29,006,327	29.00

CALCULATION OF CAPITAL PAYMENT

Provider CCN: 14-0239

Period:
From 07/01/2019
To 06/30/2020Worksheet L
Parts I-III
Date/Time Prepared:
4/22/2021 7:56 am

Title XVIII		Hospital	PPS
			1.00
PART I - FULLY PROSPECTIVE METHOD			
CAPITAL FEDERAL AMOUNT			
1.00	Capital DRG other than outlier	2,549,310	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	93,678	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)	177.17	3.00
4.00	Number of interns & residents (see instructions)	24.98	4.00
5.00	Indirect medical education percentage (see instructions)	4.06	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)	103,502	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	5.58	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	40.15	8.00
9.00	Sum of lines 7 and 8	45.73	9.00
10.00	Allowable disproportionate share percentage (see instructions)	9.70	10.00
11.00	Disproportionate share adjustment (see instructions)	247,283	11.00
12.00	Total prospective capital payments (see instructions)	2,993,773	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