

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

OMB NO. 0938-0050
EXPIRES 03-31-2022

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION
AND SETTLEMENT SUMMARY

Provider CCN: 14-0095

Period:
From 07/01/2020
To 06/30/2021

Worksheet S
Parts I-III
Date/Time Prepared:
11/29/2021 3:10 pm

PART I - COST REPORT STATUS

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

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 SAINT ANTHONY HOSPITAL (14-0095) for the cost reporting period beginning 07/01/2020 and ending 06/30/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

☒ 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) BOB ENKEMA
Officer or Administrator of Provider(s)

EXECUTIVE VP & CFO
Title

11/29/2021 03:10:15 PM
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	373,018	96,082	0	0	1.00
2.00	Subprovider - IPF	0	39,326	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
200.00	Total	0	412,344	96,082	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: 14-0095		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 11/29/2021 3:10 pm			
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 2875 W. 19TH STREET			PO Box:				1.00			
2.00	City: CHICAGO			State: IL		Zip Code: 60623		County: COOK			
		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			SAINT ANTHONY HOSPITAL	140095	16974	1	07/01/1966	N	P	O
4.00	Subprovider - IPF			SAINT ANTHONY HOSPITAL	14S095	16974	4	07/01/1984	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										
17.20	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)						07/01/2020		06/30/2021		20.00
21.00	Type of Control (see instructions)						2				21.00
							1.00	2.00	3.00		
Inpatient PPS Information											
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N				22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	Y				22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N				22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N		N		22.03
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMBdelineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N		N		22.04
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					1	N				23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0095		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 11/29/2021 3:10 pm			
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
		1.00	2.00	3.00	4.00	5.00	6.00		
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	2,576	0	17	7,245	0	24.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00	
						Urban/Rural S	Date of Geogr		
						1.00	2.00		
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					1		26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					1		27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00	
						Beginning:	Ending:		
						1.00	2.00		
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00	
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01	
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00	
						Y/N	Y/N		
						1.00	2.00		
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N	40.00	
						V	XVIII	XIX	
						1.00	2.00	3.00	
Prospective Payment System (PPS)-Capital									
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N	48.00
Teaching Hospitals									
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2.					Y	Y		56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					N			57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N			59.00

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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.		N				60.00
			Y/N	IME	Direct GME	IME	Direct GME
			1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)		N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
			Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
			1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
						1.00	
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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0095

Period:
From 07/01/2020
To 06/30/2021Worksheet S-2
Part I
Date/Time Prepared:
11/29/2021 3:10 pm

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

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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	Y		90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Y		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	Y		98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y		98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y		98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N		98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N		98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y		98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y		98.06
Rural Providers					
105.00	Does this hospital qualify as a CAH?	N			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)				106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)				107.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0095		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 11/29/2021 3:10 pm	
				V	XIX		
				1.00	2.00		
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			N			108.00
				Physical	Occupational	Speech	Respiratory
				1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.						109.00
						1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.			N			110.00
				1.00	2.00		
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.			N			111.00
				1.00	2.00	3.00	
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.			N			112.00
Miscellaneous Cost Reporting Information							
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.			N			0115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.			N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.			N			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.			1			118.00
				Premiums	Losses	Insurance	
				1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:			886,607	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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0095		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 11/29/2021 3:10 pm	
		1.00		2.00			
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00	
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00	
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00	
133.00	Removed and reserved					133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00	
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	N				140.00	
1.00		2.00		3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name:	Contractor's Name:		Contractor's Number:		141.00	
142.00	Street:	PO Box:				142.00	
143.00	City:	State:		Zip Code:		143.00	
						1.00	
144.00	Are provider based physicians' costs included in Worksheet A?			Y		144.00	
						1.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.					145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N				146.00	
						1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.			N		147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.			N		148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.			N		149.00	
		Part A		Part B		Title V	
		1.00		2.00		3.00	
						Title XIX	
						4.00	
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)							
155.00	Hospital	N		N		N	
156.00	Subprovider - IPF	N		N		N	
157.00	Subprovider - IRF	N		N		N	
158.00	SUBPROVIDER						
159.00	SNF	N		N		N	
160.00	HOME HEALTH AGENCY	N		N		N	
161.00	CMHC			N		N	
161.20	OUTPATIENT PHYSICAL THERAPY			N		N	
161.30	OUTPATIENT OCCUPATIONAL THERAPY			N		N	
161.40	OUTPATIENT SPEECH PATHOLOGY			N		N	
						1.00	
Multicampus							
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.			N		165.00	
		Name		County		State	
		0		1.00		2.00	
						3.00	
						4.00	
						5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)					0.00	
						1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.			Y		167.00	
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)					168.00	
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)					168.01	
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)			9.99		169.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0095	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part I Date/Time Prepared: 11/29/2021 3:10 pm
			Beginning 1.00	Ending 2.00
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00
			1.00	2.00
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N		0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0095		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part II Date/Time Prepared: 11/29/2021 3:10 pm	
		Y/N	Date				
		1.00	2.00				
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N					1.00
		Y/N	Date	V/I			
		1.00	2.00	3.00			
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N					2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N					3.00
		Y/N	Type	Date			
		1.00	2.00	3.00			
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	N					4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N					5.00
		Y/N	Legal Oper.				
		1.00	2.00				
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N					6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N					7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N					8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	Y					9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N					10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N					11.00
		Y/N					
		1.00					
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y					12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N					13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N					14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N					15.00
		Part A		Part B			
		Y/N	Date	Y/N	Date		
		1.00	2.00	3.00	4.00		
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N			16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	10/31/2021	Y	10/31/2021		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N			18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N			19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0095

Period:
From 07/01/2020
To 06/30/2021Worksheet S-2
Part II
Date/Time Prepared:
11/29/2021 3:10 pm

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
					1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?				36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	RAJ	SHAH		41.00
42.00	Enter the employer/company name of the cost report preparer.	STRATEGIC REIMBURSEMENT GROUP LLC			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	630-530-7100 EXT 107	RAJ.SHAH@SRGROUPLLC.COM		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0095	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part II Date/Time Prepared: 11/29/2021 3:10 pm
		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MANAGER		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0095

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part I
Date/Time Prepared:
11/29/2021 3:10 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
					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	94	34,310	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)		94	34,310	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	15	5,475	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		109	39,785	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	42	15,330		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
25.20 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)		151				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0095

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part I
Date/Time Prepared:
11/29/2021 3:10 pm

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,774	1,278	12,052			1.00
2.00	HMO and other (see instructions)	31	7,245				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,774	1,278	12,052			7.00
8.00	INTENSIVE CARE UNIT	643	557	3,842			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		526	2,331			13.00
14.00	Total (see instructions)	2,417	2,361	18,225	5.78	731.20	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	1,530	0	11,103	0.00	37.25	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)			216			24.10
25.00	CMHC - CMHC						25.00
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)				5.78	768.45	27.00
28.00	Observation Bed Days		74	3,107			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	232	287			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: 14-0095

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part I
Date/Time Prepared:
11/29/2021 3:10 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	367	438	3,512	1.00
2.00 HMO and other (see instructions)			4	1,535		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	367	438	3,512	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	183	0	1,629	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
25.20 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: 14-0095

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part II
Date/Time Prepared:
11/29/2021 3:10 pm

	Wkst. A Line Number	Amount Reported	Reclassificat ion 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	60,097,637	209,140	60,306,777	1,598,386.00	37.73 1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00 2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00 3.00
4.00	Physician-Part A - Administrative		1,742,861	0	1,742,861	12,216.00	142.67 4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00 4.01
5.00	Physician and Non Physician-Part B		4,644,243	0	4,644,243	42,782.00	108.56 5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00 6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00 7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00 7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00 8.00
9.00	SNF	44.00	0	0	0	0.00	0.00 9.00
10.00	Excluded area salaries (see instructions)		4,371,666	27,655	4,399,321	149,352.00	29.46 10.00
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		384,420	0	384,420	4,868.00	78.97 11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00 12.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00 13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00 14.00
14.01	Home office salaries		0	0	0	0.00	0.00 14.01
14.02	Related organization salaries		0	0	0	0.00	0.00 14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00 15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00 16.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00 16.01
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00 16.02
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		9,320,185	0	9,320,185		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		998,531	0	998,531		
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		81,672	0	81,672		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		286,030	0	286,030		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		0	0	0		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0095

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part II
Date/Time Prepared:
11/29/2021 3:10 pm

		Wkst. A Line Number	Amount Reported	Reclassificat ion 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	873,544	20,000	893,544	21,004.00	42.54	26.00
27.00	Administrative & General	5.00	15,932,119	108,940	16,041,059	268,302.00	59.79	27.00
28.00	Administrative & General under contract (see inst.)		1,212,969	0	1,212,969	14,478.00	83.78	28.00
29.00	Maintenance & Repairs	6.00	400,331	0	400,331	11,353.00	35.26	29.00
30.00	Operation of Plant	7.00	1,351,838	0	1,351,838	56,235.00	24.04	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	926,767	0	926,767	50,733.00	18.27	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	1,088,873	-397,647	691,226	59,868.00	11.55	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	397,647	397,647	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	912,177	3,000	915,177	47,459.00	19.28	38.00
39.00	Central Services and Supply	14.00	310,245	1,500	311,745	13,958.00	22.33	39.00
40.00	Pharmacy	15.00	1,595,998	0	1,595,998	40,086.00	39.81	40.00
41.00	Medical Records & Medical Records Library	16.00	754,003	0	754,003	24,148.00	31.22	41.00
42.00	Social Service	17.00	1,252,612	11,250	1,263,862	26,168.00	48.30	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0095

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part III
Date/Time Prepared:
11/29/2021 3:10 pm

	Worksheet A Line Number	Amount Reported	Reclassificat ion 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)	56,666,363	209,140	56,875,503	1,570,082.00	36.22	1.00
2.00	Excluded area salaries (see instructions)	4,371,666	27,655	4,399,321	149,352.00	29.46	2.00
3.00	Subtotal salaries (line 1 minus line 2)	52,294,697	181,485	52,476,182	1,420,730.00	36.94	3.00
4.00	Subtotal other wages & related costs (see inst.)	384,420	0	384,420	4,868.00	78.97	4.00
5.00	Subtotal wage-related costs (see inst.)	9,401,857	0	9,401,857	0.00	17.92	5.00
6.00	Total (sum of lines 3 thru 5)	62,080,974	181,485	62,262,459	1,425,598.00	43.67	6.00
7.00	Total overhead cost (see instructions)	26,611,476	144,690	26,756,166	633,792.00	42.22	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 14-0095

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part IV
Date/Time Prepared:
11/29/2021 3:10 pm

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	1,002,110	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	0	8.02
8.03	Health Insurance (Purchased)	4,150,541	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	183,509	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	73,188	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)	136,120	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	817,975	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
TAXES			
17.00	FICA-Employers Portion Only	4,038,553	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	207,749	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	76,674	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	10,686,419	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 14-0095

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part V
Date/Time Prepared:
11/29/2021 3:10 pm

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	384,420	10,686,419	1.00
2.00	Hospital	384,420	10,686,419	2.00
3.00	Subprovider - IPF	0	0	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
16.20	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			17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-0095	Period: From 07/01/2020 To 06/30/2021	Worksheet S-10 Date/Time Prepared: 11/29/2021 3:10 pm
				1.00
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.339127 1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid	55,891,928		2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y		3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0		5.00
6.00	Medicaid charges	155,002,214		6.00
7.00	Medicaid cost (line 1 times line 6)	52,565,436		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)	16,400,488	62	16,400,550 20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	5,561,848	62	5,561,910 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)	5,561,848	62	5,561,910 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)	17,375,274		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	502,493		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	773,066		27.01
28.00	Non-Medicare bad debt expense (see instructions)	16,602,208		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	5,900,830		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	11,462,740		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	11,462,740		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0095

Period:
From 07/01/2020
To 06/30/2021

Worksheet A

Date/Time Prepared:
11/29/2021 3:10 pm

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificat ions (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		2,992,561	2,992,561	0	2,992,561	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	0	0	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	873,544	6,086,738	6,960,282	0	6,960,282	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	15,932,119	29,148,423	45,080,542	-909,382	44,171,160	5.00
6.00	00600	MAINTENANCE & REPAIRS	400,331	1,497,337	1,897,668	0	1,897,668	6.00
7.00	00700	OPERATION OF PLANT	1,351,838	2,199,320	3,551,158	0	3,551,158	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	926,767	346,226	1,272,993	0	1,272,993	9.00
10.00	01000	DIETARY	1,088,873	1,491,378	2,580,251	-980,924	1,599,327	10.00
11.00	01100	CAFETERIA	0	0	0	980,924	980,924	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	912,177	128,452	1,040,629	0	1,040,629	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	310,245	201,944	512,189	0	512,189	14.00
15.00	01500	PHARMACY	1,595,998	1,320,740	2,916,738	-1,514,879	1,401,859	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	754,003	435,191	1,189,194	0	1,189,194	16.00
17.00	01700	SOCIAL SERVICE	1,252,612	320,123	1,572,735	0	1,572,735	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	2,309,318	832,255	3,141,573	0	3,141,573	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,507,287	1,063,569	5,570,856	-459,211	5,111,645	30.00
31.00	03100	INTENSIVE CARE UNIT	1,186,807	524,223	1,711,030	-284,278	1,426,752	31.00
40.00	04000	SUBPROVIDER - IPF	3,662,066	876,444	4,538,510	-46,636	4,491,874	40.00
43.00	04300	NURSERY	1,353,972	218,550	1,572,522	-57,350	1,515,172	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,384,298	3,518,406	4,902,704	-1,627,482	3,275,222	50.00
51.00	05100	RECOVERY ROOM	214,827	24,960	239,787	-9,616	230,171	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,140,865	957,450	5,098,315	-357,353	4,740,962	52.00
53.00	05300	ANESTHESIOLOGY	1,573,470	531,922	2,105,392	-115,891	1,989,501	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,229,573	2,209,699	4,439,272	-460,208	3,979,064	54.00
57.00	05700	CT SCAN	419,391	115,866	535,257	-61,631	473,626	57.00
58.00	05800	MRI	163,366	34,001	197,367	-21,963	175,404	58.00
60.00	06000	LABORATORY	1,602,819	1,962,468	3,565,287	0	3,565,287	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	9,935	257,381	267,316	-82,338	184,978	63.00
65.00	06500	RESPIRATORY THERAPY	854,579	352,836	1,207,415	-284,562	922,853	65.00
66.00	06600	PHYSICAL THERAPY	1,026,912	152,899	1,179,811	-34,163	1,145,648	66.00
69.00	06900	ELECTROCARDIOLOGY	342,736	129,219	471,955	-21,531	450,424	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	45,040	10,037	55,077	-2,704	52,373	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	3,918,098	3,918,098	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	751,448	751,448	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	2,424,261	2,424,261	73.00
75.00	07500	ASC (NON-DISTINCT PART)	363,311	43,360	406,671	-14,414	392,257	75.00
76.00	03951	HEMODIALYSIS	0	416,566	416,566	0	416,566	76.00
76.01	03952	DIABETES CENTER	0	0	0	0	0	76.01
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	2,795,745	2,192,306	4,988,051	-90,075	4,897,976	90.00
90.01	09001	CHEMOTHERAPY	49,388	8,442	57,830	-548	57,282	90.01
90.02	09002	KEDZIE CLINIC	420,004	119,383	539,387	-3,876	535,511	90.02
90.03	09003	LITTLE VILLAGE CLINIC	519,659	666,423	1,186,082	-1,618	1,184,464	90.03
91.00	09100	EMERGENCY	2,814,162	1,097,801	3,911,963	-632,098	3,279,865	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
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)	59,388,037	64,484,899	123,872,936	0	123,872,936	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	OTHER NON-REIMBURSABLE	114,868	10,253	125,121	0	125,121	192.01
192.02	19202	NEPHROLOGY	594,732	841,707	1,436,439	0	1,436,439	192.02
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	60,097,637	65,336,859	125,434,496	0	125,434,496	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0095

Period:
From 07/01/2020
To 06/30/2021

Worksheet A

Date/Time Prepared:
11/29/2021 3:10 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	2,992,561	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	0	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-80	6,960,202	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-7,469,826	36,701,334	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	1,897,668	6.00
7.00	00700	OPERATION OF PLANT	-16,825	3,534,333	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	8.00
9.00	00900	HOUSEKEEPING	0	1,272,993	9.00
10.00	01000	DIETARY	-71,095	1,528,232	10.00
11.00	01100	CAFETERIA	-571,793	409,131	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	-3,500	1,037,129	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	512,189	14.00
15.00	01500	PHARMACY	-190,578	1,211,281	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-265	1,188,929	16.00
17.00	01700	SOCIAL SERVICE	0	1,572,735	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	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	-2,211,972	929,601	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-677,034	4,434,611	30.00
31.00	03100	INTENSIVE CARE UNIT	-19,986	1,406,766	31.00
40.00	04000	SUBPROVIDER - IPF	-516,284	3,975,590	40.00
43.00	04300	NURSERY	-723,452	791,720	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-1,347,031	1,928,191	50.00
51.00	05100	RECOVERY ROOM	0	230,171	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-2,391,634	2,349,328	52.00
53.00	05300	ANESTHESIOLOGY	-1,720,623	268,878	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-1,320,257	2,658,897	54.00
57.00	05700	CT SCAN	0	473,626	57.00
58.00	05800	MRI	0	175,404	58.00
60.00	06000	LABORATORY	-13,634	3,551,653	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	-72	184,906	63.00
65.00	06500	RESPIRATORY THERAPY	0	922,853	65.00
66.00	06600	PHYSICAL THERAPY	-3,037	1,142,611	66.00
69.00	06900	ELECTROCARDIOLOGY	0	450,424	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	52,373	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	3,918,098	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	751,448	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,424,261	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	392,257	75.00
76.00	03951	HEMODIALYSIS	0	416,566	76.00
76.01	03952	DIABETES CENTER	0	0	76.01
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	-578,710	4,319,266	90.00
90.01	09001	CHEMOTHERAPY	0	57,282	90.01
90.02	09002	KEDZIE CLINIC	0	535,511	90.02
90.03	09003	LITTLE VILLAGE CLINIC	0	1,184,464	90.03
91.00	09100	EMERGENCY	-129,668	3,150,197	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
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)	-19,977,356	103,895,580	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
192.01	19201	OTHER NON-REIMBURSABLE	0	125,121	192.01
192.02	19202	NEPHROLOGY	0	1,436,439	192.02
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-19,977,356	105,457,140	200.00

RECLASSIFICATIONS

Provider CCN: 14-0095

Period:
From 07/01/2020
To 06/30/2021

Worksheet A-6

Date/Time Prepared:
11/29/2021 3:10 pm

	Increases				
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	B - CAFETERIA RECLASS				
1.00	CAFETERIA	11.00	397,647	583,277	1.00
	0		397,647	583,277	
	C - COST OF MEDICAL SUPPLIES				
1.00	MEDICAL SUPPLIES CHARGED TO	71.00	0	3,918,098	1.00
	PATIENT				
2.00	IMPL. DEV. CHARGED TO	72.00	0	751,448	2.00
	PATIENTS				
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
	0		0	4,669,546	
	D - COST OF DRUGS SOLD				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	2,424,261	1.00
2.00	0	0.00	0	0	2.00
	0		0	2,424,261	
	E - HIRING INCENTIVES				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	20,000	0	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	108,940	0	2.00
3.00	NURSING ADMINISTRATION	13.00	3,000	0	3.00
4.00	CENTRAL SERVICES & SUPPLY	14.00	1,500	0	4.00
5.00	SOCIAL SERVICE	17.00	11,250	0	5.00
6.00	I&R SERVICES-OTHER PRGM	22.00	10,000	0	6.00
	COSTS APPRV				
7.00	INTENSIVE CARE UNIT	31.00	1,288	0	7.00
8.00	SUBPROVIDER - IPF	40.00	27,655	0	8.00
9.00	DELIVERY ROOM & LABOR ROOM	52.00	24,250	0	9.00
10.00	PHYSICAL THERAPY	66.00	820	0	10.00
11.00	CLINIC	90.00	255	0	11.00
12.00	KEDZIE CLINIC	90.02	182	0	12.00
	0		209,140	0	
500.00	Grand Total: Increases		606,787	7,677,084	500.00

RECLASSIFICATIONS

Provider CCN: 14-0095

Period:
From 07/01/2020
To 06/30/2021

Worksheet A-6

Date/Time Prepared:
11/29/2021 3:10 pm

	Decreases				Wkst. A-7 Ref.		
	Cost Center	Line #	Salary	Other			
	6.00	7.00	8.00	9.00			10.00
1.00	B - CAFETERIA RECLASS					1.00	
	DIETARY	10.00	397,647	583,277	0		
	0		397,647	583,277			
	C - COST OF MEDICAL SUPPLIES						
1.00	ADULTS & PEDIATRICS	30.00	0	459,211	0	1.00	
2.00	INTENSIVE CARE UNIT	31.00	0	284,278	0	2.00	
3.00	SUBPROVIDER - IPF	40.00	0	46,636	0	3.00	
4.00	NURSERY	43.00	0	57,350	0	4.00	
5.00	OPERATING ROOM	50.00	0	1,627,482	0	5.00	
6.00	RECOVERY ROOM	51.00	0	9,616	0	6.00	
7.00	DELIVERY ROOM & LABOR ROOM	52.00	0	357,353	0	7.00	
8.00	ANESTHESIOLOGY	53.00	0	115,891	0	8.00	
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	460,208	0	9.00	
10.00	CT SCAN	57.00	0	61,631	0	10.00	
11.00	MRI	58.00	0	21,963	0	11.00	
12.00	BLOOD STORING, PROCESSING & TRANS.	63.00	0	82,338	0	12.00	
13.00	RESPIRATORY THERAPY	65.00	0	284,562	0	13.00	
14.00	PHYSICAL THERAPY	66.00	0	34,163	0	14.00	
15.00	ELECTROCARDIOLOGY	69.00	0	21,531	0	15.00	
16.00	ELECTROENCEPHALOGRAPHY	70.00	0	2,704	0	16.00	
17.00	ASC (NON-DISTINCT PART)	75.00	0	14,414	0	17.00	
18.00	CLINIC	90.00	0	90,075	0	18.00	
19.00	CHEMOTHERAPY	90.01	0	548	0	19.00	
20.00	KEDZIE CLINIC	90.02	0	3,876	0	20.00	
21.00	LITTLE VILLAGE CLINIC	90.03	0	1,618	0	21.00	
22.00	EMERGENCY	91.00	0	632,098	0	22.00	
	0		0	4,669,546			
	D - COST OF DRUGS SOLD						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	909,382	0	1.00	
2.00	PHARMACY	15.00	0	1,514,879	0	2.00	
	0		0	2,424,261			
	E - HIRING INCENTIVES						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	20,000	0	1.00	
2.00	ADMINISTRATIVE & GENERAL	5.00	0	108,940	0	2.00	
3.00	NURSING ADMINISTRATION	13.00	0	3,000	0	3.00	
4.00	CENTRAL SERVICES & SUPPLY	14.00	0	1,500	0	4.00	
5.00	SOCIAL SERVICE	17.00	0	11,250	0	5.00	
6.00	I&R SERVICES-OTHER PRGM	22.00	0	10,000	0	6.00	
	COSTS APPRV						
7.00	INTENSIVE CARE UNIT	31.00	0	1,288	0	7.00	
8.00	SUBPROVIDER - IPF	40.00	0	27,655	0	8.00	
9.00	DELIVERY ROOM & LABOR ROOM	52.00	0	24,250	0	9.00	
10.00	PHYSICAL THERAPY	66.00	0	820	0	10.00	
11.00	CLINIC	90.00	0	255	0	11.00	
12.00	KEDZIE CLINIC	90.02	0	182	0	12.00	
	0		0	209,140			
500.00	Grand Total: Decreases		397,647	7,886,224		500.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0095

Period:
From 07/01/2020
To 06/30/2021Worksheet A-7
Part I
Date/Time Prepared:
11/29/2021 3:10 pm

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	472,850	0	0	0	0	1.00
2.00	Land Improvements	518,789	31,952	0	31,952	0	2.00
3.00	Buildings and Fixtures	26,857,699	451,590	0	451,590	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	48,739,035	1,066,734	0	1,066,734	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	76,588,373	1,550,276	0	1,550,276	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	76,588,373	1,550,276	0	1,550,276	0	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	472,850	0				1.00
2.00	Land Improvements	550,741	0				2.00
3.00	Buildings and Fixtures	27,309,289	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	49,805,769	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	78,138,649	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	78,138,649	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0095

Period:
From 07/01/2020
To 06/30/2021Worksheet A-7
Part II
Date/Time Prepared:
11/29/2021 3:10 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	2,992,561	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)	2,992,561	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Relat ed 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	2,992,561				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	2,992,561				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0095

Period:
From 07/01/2020
To 06/30/2021Worksheet A-7
Part III
Date/Time Prepared:
11/29/2021 3:10 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	27,860,030	0	27,860,030	0.358717	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	49,805,769	0	49,805,769	0.641283	0	2.00
3.00	Total (sum of lines 1-2)	77,665,799	0	77,665,799	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Relat ed Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	2,992,561	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	2,992,561	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Relat ed Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	2,992,561	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	2,992,561	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0095

Period:
From 07/01/2020
To 06/30/2021

Worksheet A-8

Date/Time Prepared:
11/29/2021 3:10 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
				3.00	4.00		
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP 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)	B	-18,223	ADMINISTRATIVE & GENERAL	5.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-10,263,774			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	0			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-571,793	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	-265	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
19.01	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.01
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0095

Period:
From 07/01/2020
To 06/30/2021

Worksheet A-8

Date/Time Prepared:
11/29/2021 3:10 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
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	OTHER REVENUE	B	-80	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.00
36.00	OTHER REVENUE	B	-101,269	ADMINISTRATIVE & GENERAL	5.00	0	36.00
36.01	OTHER REVENUE	B	-16,825	OPERATION OF PLANT	7.00	0	36.01
36.02	OTHER REVENUE	B	-71,095	DIETARY	10.00	0	36.02
36.03	OTHER REVENUE	B	-3,500	NURSING ADMINISTRATION	13.00	0	36.03
36.04	OTHER REVENUE	B	-190,578	PHARMACY	15.00	0	36.04
36.05	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	36.05
36.06	OTHER REVENUE	B	-13,634	LABORATORY	60.00	0	36.06
36.07	OTHER REVENUE	B	-72	BLOOD STORING, PROCESSING & TRANS.	63.00	0	36.07
36.08	OTHER REVENUE	B	-20,508	CLINIC	90.00	0	36.08
36.09	MILLENIUM BLDG-1ST FLOOR	A	-92,402	ADMINISTRATIVE & GENERAL	5.00	0	36.09
36.10	MEDICAID ASSESSMENT TAX	A	-7,229,612	ADMINISTRATIVE & GENERAL	5.00	0	36.10
36.11	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	36.11
36.12	MIDWIFERY PROGRAM	A	-1,355,406	DELIVERY ROOM & LABOR ROOM	52.00	0	36.12
36.13	IHA - NON ALLOWABLE DUES	A	-28,320	ADMINISTRATIVE & GENERAL	5.00	0	36.13
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-19,977,356				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.

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0095

Period:
From 07/01/2020
To 06/30/2021

Worksheet A-8-2

Date/Time Prepared:
11/29/2021 3:10 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	22.00	AGGREGATE-I&R SERVICES-OTHER PRGM CO	2,592,265	2,158,402	433,863	211,500	3,740	1.00
2.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	677,034	677,034	0	0	0	2.00
3.00	31.00	AGGREGATE-INTENSIVE CARE UNIT	110,000	0	110,000	197,500	948	3.00
4.00	40.00	AGGREGATE-SUBPROVIDER - IPF	521,775	514,467	7,308	181,300	63	4.00
5.00	43.00	AGGREGATE-NURSERY	723,452	723,452	0	0	0	5.00
6.00	50.00	AGGREGATE-OPERATING ROOM	1,347,031	1,347,031	0	0	0	6.00
7.00	52.00	AGGREGATE-DELIVERY ROOM & LABOR ROOM	1,036,228	1,036,228	0	0	0	7.00
8.00	53.00	AGGREGATE-ANESTHESIOLOGY	1,720,623	1,720,623	0	0	0	8.00
9.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	1,320,257	1,320,257	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
11.00	60.00	AGGREGATE-LABORATORY	6,000	0	6,000	260,300	52	11.00
12.00	66.00	AGGREGATE-PHYSICAL THERAPY	25,000	0	25,000	211,500	216	12.00
13.00	90.00	AGGREGATE-CLINIC	616,291	537,991	78,300	179,000	675	13.00
15.00	91.00	AGGREGATE-EMERGENCY	129,668	129,668	0	0	0	15.00
200.00			10,825,624	10,165,153	660,471		5,694	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	22.00	AGGREGATE-I&R SERVICES-OTHER PRGM CO	380,293	19,015	0	0	0	1.00
2.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	31.00	AGGREGATE-INTENSIVE CARE UNIT	90,014	4,501	0	0	0	3.00
4.00	40.00	AGGREGATE-SUBPROVIDER - IPF	5,491	275	0	0	0	4.00
5.00	43.00	AGGREGATE-NURSERY	0	0	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	0	0	0	0	0	8.00
9.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
11.00	60.00	AGGREGATE-LABORATORY	6,508	325	0	0	0	11.00
12.00	66.00	AGGREGATE-PHYSICAL THERAPY	21,963	1,098	0	0	0	12.00
13.00	90.00	AGGREGATE-CLINIC	58,089	2,904	0	0	0	13.00
15.00	91.00	AGGREGATE-EMERGENCY	0	0	0	0	0	15.00
200.00			562,358	28,118	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	22.00	AGGREGATE-I&R SERVICES-OTHER PRGM CO	0	380,293	53,570	2,211,972		1.00
2.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	677,034		2.00
3.00	31.00	AGGREGATE-INTENSIVE CARE UNIT	0	90,014	19,986	19,986		3.00
4.00	40.00	AGGREGATE-SUBPROVIDER - IPF	0	5,491	1,817	516,284		4.00
5.00	43.00	AGGREGATE-NURSERY	0	0	0	723,452		5.00
6.00	50.00	AGGREGATE-OPERATING ROOM	0	0	0	1,347,031		6.00
7.00	52.00	AGGREGATE-DELIVERY ROOM & LABOR ROOM	0	0	0	1,036,228		7.00
8.00	53.00	AGGREGATE-ANESTHESIOLOGY	0	0	0	1,720,623		8.00
9.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	0	0	0	1,320,257		9.00
10.00	0.00		0	0	0	0		10.00
11.00	60.00	AGGREGATE-LABORATORY	0	6,508	0	0		11.00
12.00	66.00	AGGREGATE-PHYSICAL THERAPY	0	21,963	3,037	3,037		12.00
13.00	90.00	AGGREGATE-CLINIC	0	58,089	20,211	558,202		13.00
15.00	91.00	AGGREGATE-EMERGENCY	0	0	0	129,668		15.00
200.00			0	562,358	98,621	10,263,774		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0095

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part I
Date/Time Prepared:
11/29/2021 3:10 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	4A
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,992,561	2,992,561			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0		0		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	6,960,202	11,769	0	6,971,971	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	36,701,334	369,168	0	1,882,378	5.00
6.00	00600	MAINTENANCE & REPAIRS	1,897,668	111,828	0	46,978	6.00
7.00	00700	OPERATION OF PLANT	3,534,333	368,990	0	158,634	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	52,171	0	0	8.00
9.00	00900	HOUSEKEEPING	1,272,993	26,861	0	108,753	9.00
10.00	01000	DIETARY	1,528,232	54,149	0	81,113	10.00
11.00	01100	CAFETERIA	409,131	74,985	0	46,663	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	1,037,129	52,377	0	107,393	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	512,189	77,230	0	36,582	14.00
15.00	01500	PHARMACY	1,211,281	42,705	0	187,286	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,188,929	54,563	0	88,480	16.00
17.00	01700	SOCIAL SERVICE	1,572,735	14,737	0	148,310	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	929,601	0	0	272,165	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	4,434,611	622,346	0	528,917	30.00
31.00	03100	INTENSIVE CARE UNIT	1,406,766	84,672	0	139,419	31.00
40.00	04000	SUBPROVIDER - IPF	3,975,590	186,164	0	432,978	40.00
43.00	04300	NURSERY	791,720	18,724	0	158,885	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,928,191	85,617	0	162,443	50.00
51.00	05100	RECOVERY ROOM	230,171	0	0	25,209	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,349,328	57,339	0	488,764	52.00
53.00	05300	ANESTHESIOLOGY	268,878	11,045	0	184,642	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,658,807	158,727	0	261,634	54.00
57.00	05700	CT SCAN	473,626	0	0	49,214	57.00
58.00	05800	MRI	175,404	0	0	19,171	58.00
60.00	06000	LABORATORY	3,551,653	105,272	0	188,086	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	184,906	0	0	1,166	63.00
65.00	06500	RESPIRATORY THERAPY	922,853	19,389	0	100,282	65.00
66.00	06600	PHYSICAL THERAPY	1,142,611	25,517	0	120,601	66.00
69.00	06900	ELECTROCARDIOLOGY	450,424	14,796	0	40,219	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	52,373	9,347	0	5,285	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,918,098	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	751,448	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,424,261	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	392,257	0	0	42,633	75.00
76.00	03951	HEMODIALYSIS	416,566	0	0	0	76.00
76.01	03952	DIABETES CENTER	0	0	0	0	76.01
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	4,319,266	89,220	0	328,102	90.00
90.01	09001	CHEMOTHERAPY	57,282	0	0	5,796	90.01
90.02	09002	KEDZIE CLINIC	535,511	0	0	49,308	90.02
90.03	09003	LITTLE VILLAGE CLINIC	1,184,464	0	0	60,980	90.03
91.00	09100	EMERGENCY	3,150,197	54,858	0	330,233	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
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)	103,895,580	2,854,566	0	6,888,702	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,215	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	135,780	0	0	192.00
192.01	19201	OTHER NON-REIMBURSABLE	125,121	0	0	13,479	192.01
192.02	19202	NEPHROLOGY	1,436,439	0	0	69,790	192.02

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0095

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part I
Date/Time Prepared:
11/29/2021 3:10 pm

Cost Center Description			Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	105,457,140	2,992,561	0	6,971,971	105,457,140	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0095

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part I
Date/Time Prepared:
11/29/2021 3:10 pm

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	38,952,880					5.00
6.00	00600	MAINTENANCE & REPAIRS	1,204,518	3,260,992				6.00
7.00	00700	OPERATION OF PLANT	2,379,169	481,349	6,922,475			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	30,558	68,057	169,490	320,276		8.00
9.00	00900	HOUSEKEEPING	825,049	35,040	87,264	0	2,355,960	9.00
10.00	01000	DIETARY	974,342	70,638	175,919	0	62,177	10.00
11.00	01100	CAFETERIA	310,888	97,819	243,609	0	86,102	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	701,048	68,327	170,162	0	60,143	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	366,661	100,747	250,901	0	88,680	14.00
15.00	01500	PHARMACY	844,182	55,709	138,739	0	49,037	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	780,163	71,178	177,262	0	62,652	16.00
17.00	01700	SOCIAL SERVICE	1,016,682	19,225	47,878	0	16,922	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	703,898	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,271,766	811,847	2,021,843	131,613	714,608	30.00
31.00	03100	INTENSIVE CARE UNIT	955,226	110,455	275,080	41,957	97,225	31.00
40.00	04000	SUBPROVIDER - IPF	2,691,226	242,851	604,801	121,250	213,764	40.00
43.00	04300	NURSERY	567,755	24,426	60,830	25,456	21,500	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,274,674	111,688	278,150	0	98,311	50.00
51.00	05100	RECOVERY ROOM	149,581	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,695,912	74,799	186,281	0	65,840	52.00
53.00	05300	ANESTHESIOLOGY	272,105	14,409	35,884	0	12,683	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,803,530	207,060	515,667	0	182,259	54.00
57.00	05700	CT SCAN	306,238	0	0	0	0	57.00
58.00	05800	MRI	113,966	0	0	0	0	58.00
60.00	06000	LABORATORY	2,252,100	137,327	342,003	0	120,879	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	108,986	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	610,627	25,293	62,989	0	22,263	65.00
66.00	06600	PHYSICAL THERAPY	754,834	33,287	82,898	0	29,300	66.00
69.00	06900	ELECTROCARDIOLOGY	296,046	19,302	48,069	0	16,990	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	39,246	12,194	30,367	0	10,733	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,294,908	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	440,138	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,419,938	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	254,724	0	0	0	0	75.00
76.00	03951	HEMODIALYSIS	243,991	0	0	0	0	76.00
76.01	03952	DIABETES CENTER	0	0	0	0	0	76.01
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	2,774,314	116,388	289,856	0	102,448	90.00
90.01	09001	CHEMOTHERAPY	36,946	0	0	0	0	90.01
90.02	09002	KEDZIE CLINIC	342,540	0	0	0	0	90.02
90.03	09003	LITTLE VILLAGE CLINIC	729,481	0	0	0	0	90.03
91.00	09100	EMERGENCY	2,070,689	71,563	178,221	0	62,991	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
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)	37,908,645	3,080,978	6,474,163	320,276	2,197,507	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,297	2,889	7,196	0	2,543	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	79,529	177,125	441,116	0	155,910	192.00
192.01	19201	OTHER NON-REIMBURSABLE	81,181	0	0	0	0	192.01
192.02	19202	NEPHROLOGY	882,228	0	0	0	0	192.02
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	38,952,880	3,260,992	6,922,475	320,276	2,355,960	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0095

Period:
From 07/01/2020
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Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATIO N	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	2,946,570					10.00
11.00	01100	CAFETERIA	0	1,269,197				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	57,875	0	2,254,454		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	17,018	0	0	1,450,008	14.00
15.00	01500	PHARMACY	0	48,872	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	29,445	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	31,905	0	0	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	28,253	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,345,126	216,791	0	613,610	0	30.00
31.00	03100	INTENSIVE CARE UNIT	411,693	68,755	0	194,607	0	31.00
40.00	04000	SUBPROVIDER - IPF	1,189,751	94,472	0	267,396	0	40.00
43.00	04300	NURSERY	0	31,854	0	90,161	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	43,825	0	124,043	0	50.00
51.00	05100	RECOVERY ROOM	0	5,301	0	15,003	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	111,997	0	316,999	0	52.00
53.00	05300	ANESTHESIOLOGY	0	15,318	0	43,358	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	85,240	0	0	0	54.00
57.00	05700	CT SCAN	0	9,511	0	0	0	57.00
58.00	05800	MRI	0	5,022	0	0	0	58.00
60.00	06000	LABORATORY	0	63,074	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	2,942	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	28,963	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	39,234	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	13,721	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2,004	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	1,184,207	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	227,118	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	12,097	0	34,241	0	75.00
76.00	03951	HEMODIALYSIS	0	0	0	0	0	76.00
76.01	03952	DIABETES CENTER	0	0	0	0	0	76.01
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	69,567	0	196,904	0	90.00
90.01	09001	CHEMOTHERAPY	0	2,511	0	7,107	0	90.01
90.02	09002	KEDZIE CLINIC	0	0	0	0	0	90.02
90.03	09003	LITTLE VILLAGE CLINIC	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	124,018	0	351,025	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
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)	2,946,570	1,259,585	0	2,254,454	1,411,325	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	OTHER NON-REIMBURSABLE	0	9,612	0	0	0	192.01
192.02	19202	NEPHROLOGY	0	0	0	0	38,683	192.02
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
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)	2,946,570	1,269,197	0	2,254,454	1,450,008	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0095

Period:
From 07/01/2020
To 06/30/2021Worksheet 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	
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	2,577,811					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,452,672				16.00
17.00	01700	SOCIAL SERVICE	0	0	2,868,394			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	PARAMED ED PRGM-(SPECIFY)	0	0	0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	263,723	1,178,733	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	53	115,161	375,763	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	150,992	1,085,917	0	0	40.00
43.00	04300	NURSERY	0	28,558	227,981	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	232	116,536	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	6,471	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	70,864	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	67	43,073	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	171,065	0	0	0	54.00
57.00	05700	CT SCAN	0	162,773	0	0	0	57.00
58.00	05800	MRI	0	19,098	0	0	0	58.00
60.00	06000	LABORATORY	0	248,177	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	26,513	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	87,081	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	52,595	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	40,338	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	9,648	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	51,443	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	22,897	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,576,823	230,619	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	3,551	0	0	0	75.00
76.00	03951	HEMODIALYSIS	0	5,121	0	0	0	76.00
76.01	03952	DIABETES CENTER	0	0	0	0	0	76.01
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	134,683	0	0	0	90.00
90.01	09001	CHEMOTHERAPY	0	1,359	0	0	0	90.01
90.02	09002	KEDZIE CLINIC	0	29,892	0	0	0	90.02
90.03	09003	LITTLE VILLAGE CLINIC	0	27,077	0	0	0	90.03
91.00	09100	EMERGENCY	636	333,364	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
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)	2,577,811	2,452,672	2,868,394	0	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	OTHER NON-REIMBURSABLE	0	0	0	0	0	192.01
192.02	19202	NEPHROLOGY	0	0	0	0	0	192.02
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,577,811	2,452,672	2,868,394	0	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0095

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part I
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11/29/2021 3:10 pm

Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
			21.00	22.00	23.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	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	0					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		1,933,917				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)			0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	773,567	0	16,929,101	-773,567	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	4,276,832	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	11,257,152	0	40.00
43.00	04300	NURSERY	0	0	0	2,047,850	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	4,223,710	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	431,736	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	5,418,123	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	901,462	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	6,043,989	0	54.00
57.00	05700	CT SCAN	0	0	0	1,001,362	0	57.00
58.00	05800	MRI	0	0	0	332,661	0	58.00
60.00	06000	LABORATORY	0	0	0	7,008,571	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	324,513	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,879,740	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	2,280,877	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	939,905	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	171,197	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	7,448,656	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,441,601	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	6,651,641	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	739,503	0	75.00
76.00	03951	HEMODIALYSIS	0	0	0	665,678	0	76.00
76.01	03952	DIABETES CENTER	0	0	0	0	0	76.01
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	386,783	0	8,807,531	-386,783	90.00
90.01	09001	CHEMOTHERAPY	0	0	0	111,001	0	90.01
90.02	09002	KEDZIE CLINIC	0	0	0	957,251	0	90.02
90.03	09003	LITTLE VILLAGE CLINIC	0	0	0	2,002,002	0	90.03
91.00	09100	EMERGENCY	0	773,567	0	7,501,362	-773,567	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0				0	92.00
OTHER REIMBURSABLE COST CENTERS								
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	1,933,917	0	101,795,007	-1,933,917	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	16,140	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	989,460	0	192.00
192.01	19201	OTHER NON-REIMBURSABLE	0	0	0	229,393	0	192.01
192.02	19202	NEPHROLOGY	0	0	0	2,427,140	0	192.02

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0095

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part I
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11/29/2021 3:10 pm

Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			SERVICES-SALA RY & FRINGES APPRV	SERVICES-OTHE R PRGM COSTS APPRV				
			21.00	22.00				
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
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)	0	1,933,917	0	105,457,140	-1,933,917	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0095

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part I
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11/29/2021 3:10 pm

Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	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	PARAMED ED PRGM-(SPECIFY)	23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
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
57.00	05700	CT SCAN	57.00
58.00	05800	MRI	58.00
60.00	06000	LABORATORY	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	63.00
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
75.00	07500	ASC (NON-DISTINCT PART)	75.00
76.00	03951	HEMODIALYSIS	76.00
76.01	03952	DIABETES CENTER	76.01
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	09001	CHEMOTHERAPY	90.01
90.02	09002	KEDZIE CLINIC	90.02
90.03	09003	LITTLE VILLAGE CLINIC	90.03
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	92.00
OTHER REIMBURSABLE COST CENTERS			
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)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
192.01	19201	OTHER NON-REIMBURSABLE	192.01
192.02	19202	NEPHROLOGY	192.02
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	194.00
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0095

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
Date/Time Prepared:
11/29/2021 3:10 pm

Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	11,769	0	11,769	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	604,280	369,168	0	973,448	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	111,828	0	111,828	6.00
7.00	00700	OPERATION OF PLANT	0	368,990	0	368,990	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	52,171	0	52,171	8.00
9.00	00900	HOUSEKEEPING	0	26,861	0	26,861	9.00
10.00	01000	DIETARY	0	54,149	0	54,149	10.00
11.00	01100	CAFETERIA	0	74,985	0	74,985	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	52,377	0	52,377	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	77,230	0	77,230	14.00
15.00	01500	PHARMACY	0	42,705	0	42,705	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	54,563	0	54,563	16.00
17.00	01700	SOCIAL SERVICE	0	14,737	0	14,737	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	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	622,346	0	622,346	30.00
31.00	03100	INTENSIVE CARE UNIT	0	84,672	0	84,672	31.00
40.00	04000	SUBPROVIDER - IPF	0	186,164	0	186,164	40.00
43.00	04300	NURSERY	0	18,724	0	18,724	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	306,108	85,617	0	391,725	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	57,339	0	57,339	52.00
53.00	05300	ANESTHESIOLOGY	0	11,045	0	11,045	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,406	158,727	0	161,133	54.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
60.00	06000	LABORATORY	34,287	105,272	0	139,559	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
65.00	06500	RESPIRATORY THERAPY	0	19,389	0	19,389	65.00
66.00	06600	PHYSICAL THERAPY	0	25,517	0	25,517	66.00
69.00	06900	ELECTROCARDIOLOGY	0	14,796	0	14,796	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	9,347	0	9,347	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
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
76.00	03951	HEMODIALYSIS	0	0	0	0	76.00
76.01	03952	DIABETES CENTER	0	0	0	0	76.01
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	233,592	89,220	0	322,812	90.00
90.01	09001	CHEMOTHERAPY	0	0	0	0	90.01
90.02	09002	KEDZIE CLINIC	0	0	0	0	90.02
90.03	09003	LITTLE VILLAGE CLINIC	451,464	0	0	451,464	90.03
91.00	09100	EMERGENCY	7,870	54,858	0	62,728	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
OTHER REIMBURSABLE COST CENTERS							
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)	1,640,007	2,854,566	0	4,494,573	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2,215	0	2,215	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	135,780	0	135,780	192.00
192.01	19201	OTHER NON-REIMBURSABLE	0	0	0	0	192.01
192.02	19202	NEPHROLOGY	0	0	0	0	192.02
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0095

Period:
From 07/01/2020
To 06/30/2021Worksheet 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			
		0	1.00	2.00	2A	4.00	
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)	1,640,007	2,992,561	0	4,632,568	11,769	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0095

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
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Cost Center Description			ADMINISTRATIVE E & 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	976,630					5.00
6.00	00600	MAINTENANCE & REPAIRS	30,199	142,106				6.00
7.00	00700	OPERATION OF PLANT	59,650	20,976	449,884			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	766	2,966	11,015	66,918		8.00
9.00	00900	HOUSEKEEPING	20,685	1,527	5,671	0	54,927	9.00
10.00	01000	DIETARY	24,428	3,078	11,433	0	1,450	10.00
11.00	01100	CAFETERIA	7,794	4,263	15,832	0	2,007	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	17,576	2,978	11,059	0	1,402	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	9,193	4,390	16,306	0	2,067	14.00
15.00	01500	PHARMACY	21,165	2,428	9,017	0	1,143	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	19,560	3,102	11,520	0	1,461	16.00
17.00	01700	SOCIAL SERVICE	25,490	838	3,112	0	395	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	17,648	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	82,048	35,377	131,396	27,499	16,661	30.00
31.00	03100	INTENSIVE CARE UNIT	23,949	4,813	17,877	8,766	2,267	31.00
40.00	04000	SUBPROVIDER - IPF	67,474	10,583	39,305	25,334	4,984	40.00
43.00	04300	NURSERY	14,235	1,064	3,953	5,319	501	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	31,958	4,867	18,077	0	2,292	50.00
51.00	05100	RECOVERY ROOM	3,750	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	42,519	3,260	12,106	0	1,535	52.00
53.00	05300	ANESTHESIOLOGY	6,822	628	2,332	0	296	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	45,218	9,023	33,513	0	4,249	54.00
57.00	05700	CT SCAN	7,678	0	0	0	0	57.00
58.00	05800	MRI	2,857	0	0	0	0	58.00
60.00	06000	LABORATORY	56,464	5,984	22,226	0	2,818	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,732	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	15,309	1,102	4,094	0	519	65.00
66.00	06600	PHYSICAL THERAPY	18,925	1,451	5,387	0	683	66.00
69.00	06900	ELECTROCARDIOLOGY	7,422	841	3,124	0	396	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	984	531	1,974	0	250	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	57,537	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,035	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	35,600	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	6,386	0	0	0	0	75.00
76.00	03951	HEMODIALYSIS	6,117	0	0	0	0	76.00
76.01	03952	DIABETES CENTER	0	0	0	0	0	76.01
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	69,557	5,072	18,837	0	2,388	90.00
90.01	09001	CHEMOTHERAPY	926	0	0	0	0	90.01
90.02	09002	KEDZIE CLINIC	8,588	0	0	0	0	90.02
90.03	09003	LITTLE VILLAGE CLINIC	18,289	0	0	0	0	90.03
91.00	09100	EMERGENCY	51,916	3,119	11,582	0	1,469	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
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)	950,449	134,261	420,748	66,918	51,233	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	33	126	468	0	59	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,994	7,719	28,668	0	3,635	192.00
192.01	19201	OTHER NON-REIMBURSABLE	2,035	0	0	0	0	192.01
192.02	19202	NEPHROLOGY	22,119	0	0	0	0	192.02
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	976,630	142,106	449,884	66,918	54,927	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0095

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATIO N	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	94,675					10.00
11.00	01100	CAFETERIA	0	104,960				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	4,786	0	90,359		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,407	0	0	110,655	14.00
15.00	01500	PHARMACY	0	4,042	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,435	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	2,638	0	0	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	2,336	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	43,220	17,929	0	24,594	0	30.00
31.00	03100	INTENSIVE CARE UNIT	13,228	5,686	0	7,800	0	31.00
40.00	04000	SUBPROVIDER - IPF	38,227	7,813	0	10,717	0	40.00
43.00	04300	NURSERY	0	2,634	0	3,614	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	3,624	0	4,972	0	50.00
51.00	05100	RECOVERY ROOM	0	438	0	601	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	9,262	0	12,705	0	52.00
53.00	05300	ANESTHESIOLOGY	0	1,267	0	1,738	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	7,049	0	0	0	54.00
57.00	05700	CT SCAN	0	787	0	0	0	57.00
58.00	05800	MRI	0	415	0	0	0	58.00
60.00	06000	LABORATORY	0	5,216	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	243	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	2,395	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	3,245	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	1,135	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	166	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	90,371	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	17,332	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	1,000	0	1,372	0	75.00
76.00	03951	HEMODIALYSIS	0	0	0	0	0	76.00
76.01	03952	DIABETES CENTER	0	0	0	0	0	76.01
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	5,753	0	7,892	0	90.00
90.01	09001	CHEMOTHERAPY	0	208	0	285	0	90.01
90.02	09002	KEDZIE CLINIC	0	0	0	0	0	90.02
90.03	09003	LITTLE VILLAGE CLINIC	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	10,256	0	14,069	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
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)	94,675	104,165	0	90,359	107,703	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	OTHER NON-REIMBURSABLE	0	795	0	0	0	192.01
192.02	19202	NEPHROLOGY	0	0	0	0	2,952	192.02
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
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)	94,675	104,960	0	90,359	110,655	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0095

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
Date/Time Prepared:
11/29/2021 3:10 pm

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	80,816					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	92,790				16.00
17.00	01700	SOCIAL SERVICE	0	0	47,460			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	PARAMED ED PRGM-(SPECIFY)	0	0	0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	9,974	19,504			30.00
31.00	03100	INTENSIVE CARE UNIT	2	4,355	6,217			31.00
40.00	04000	SUBPROVIDER - IPF	0	5,710	17,967			40.00
43.00	04300	NURSERY	0	1,080	3,772			43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	7	4,407	0			50.00
51.00	05100	RECOVERY ROOM	0	245	0			51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,680	0			52.00
53.00	05300	ANESTHESIOLOGY	2	1,629	0			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	6,470	0			54.00
57.00	05700	CT SCAN	0	6,156	0			57.00
58.00	05800	MRI	0	722	0			58.00
60.00	06000	LABORATORY	0	9,386	0			60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0			62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	1,003	0			63.00
65.00	06500	RESPIRATORY THERAPY	0	3,293	0			65.00
66.00	06600	PHYSICAL THERAPY	0	1,989	0			66.00
69.00	06900	ELECTROCARDIOLOGY	0	1,526	0			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	365	0			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,946	0			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	866	0			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	80,785	8,722	0			73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	134	0			75.00
76.00	03951	HEMODIALYSIS	0	194	0			76.00
76.01	03952	DIABETES CENTER	0	0	0			76.01
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	5,094	0			90.00
90.01	09001	CHEMOTHERAPY	0	51	0			90.01
90.02	09002	KEDZIE CLINIC	0	1,131	0			90.02
90.03	09003	LITTLE VILLAGE CLINIC	0	1,024	0			90.03
91.00	09100	EMERGENCY	20	12,638	0			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
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)	80,816	92,790	47,460	0	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0			190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0			192.00
192.01	19201	OTHER NON-REIMBURSABLE	0	0	0			192.01
192.02	19202	NEPHROLOGY	0	0	0			192.02
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0			194.00
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)	80,816	92,790	47,460	0	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0095

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
Date/Time Prepared:
11/29/2021 3:10 pm

Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
			21.00	22.00	23.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	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	0					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		20,443				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)			0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS				1,031,440	0	30.00
31.00	03100	INTENSIVE CARE UNIT				179,867	0	31.00
40.00	04000	SUBPROVIDER - IPF				415,009	0	40.00
43.00	04300	NURSERY				55,164	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM				462,203	0	50.00
51.00	05100	RECOVERY ROOM				5,077	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM				142,231	0	52.00
53.00	05300	ANESTHESIOLOGY				26,071	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC				267,096	0	54.00
57.00	05700	CT SCAN				14,704	0	57.00
58.00	05800	MRI				4,026	0	58.00
60.00	06000	LABORATORY				241,970	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS				0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.				3,980	0	63.00
65.00	06500	RESPIRATORY THERAPY				46,270	0	65.00
66.00	06600	PHYSICAL THERAPY				57,400	0	66.00
69.00	06900	ELECTROCARDIOLOGY				29,308	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY				13,626	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT				149,854	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS				29,233	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS				125,107	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)				8,964	0	75.00
76.00	03951	HEMODIALYSIS				6,311	0	76.00
76.01	03952	DIABETES CENTER				0	0	76.01
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				437,959	0	90.00
90.01	09001	CHEMOTHERAPY				1,480	0	90.01
90.02	09002	KEDZIE CLINIC				9,802	0	90.02
90.03	09003	LITTLE VILLAGE CLINIC				470,880	0	90.03
91.00	09100	EMERGENCY				168,354	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
OTHER REIMBURSABLE COST CENTERS								
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)	0	0	0	4,403,386	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN				2,901	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES				177,796	0	192.00
192.01	19201	OTHER NON-REIMBURSABLE				2,853	0	192.01
192.02	19202	NEPHROLOGY				25,189	0	192.02

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0095

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
Date/Time Prepared:
11/29/2021 3:10 pm

Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			SERVICES-SALA RY & FRINGES APPRV	SERVICES-OTHE R PRGM COSTS APPRV				
			21.00	22.00				
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS				0	0	194.00
200.00		Cross Foot Adjustments	0	20,443	0	20,443	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	20,443	0	4,632,568	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0095

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
Date/Time Prepared:
11/29/2021 3:10 pm

Cost Center Description		Total	
		26.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	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	PARAMED ED PRGM-(SPECIFY)	23.00
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
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
57.00	05700	CT SCAN	57.00
58.00	05800	MRI	58.00
60.00	06000	LABORATORY	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	63.00
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
75.00	07500	ASC (NON-DISTINCT PART)	75.00
76.00	03951	HEMODIALYSIS	76.00
76.01	03952	DIABETES CENTER	76.01
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	09001	CHEMOTHERAPY	90.01
90.02	09002	KEDZIE CLINIC	90.02
90.03	09003	LITTLE VILLAGE CLINIC	90.03
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	92.00
OTHER REIMBURSABLE COST CENTERS			
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)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
192.01	19201	OTHER NON-REIMBURSABLE	192.01
192.02	19202	NEPHROLOGY	192.02
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	194.00
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0095

Period:
From 07/01/2020
To 06/30/2021

Worksheet B-1

Date/Time Prepared:
11/29/2021 3:10 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	202,656					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		202,656				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	797	797	59,413,233			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	25,000	25,000	16,041,059	-38,952,880	66,504,260	5.00
6.00	00600	MAINTENANCE & REPAIRS	7,573	7,573	400,331	0	2,056,474	6.00
7.00	00700	OPERATION OF PLANT	24,988	24,988	1,351,838	0	4,061,957	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,533	3,533	0	0	52,171	8.00
9.00	00900	HOUSEKEEPING	1,819	1,819	926,767	0	1,408,607	9.00
10.00	01000	DIETARY	3,667	3,667	691,226	0	1,663,494	10.00
11.00	01100	CAFETERIA	5,078	5,078	397,647	0	530,779	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	3,547	3,547	915,177	0	1,196,899	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,230	5,230	311,745	0	626,001	14.00
15.00	01500	PHARMACY	2,892	2,892	1,595,998	0	1,441,272	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,695	3,695	754,003	0	1,331,972	16.00
17.00	01700	SOCIAL SERVICE	998	998	1,263,862	0	1,735,782	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	0	2,319,318	0	1,201,766	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	42,145	42,145	4,507,287	0	5,585,874	30.00
31.00	03100	INTENSIVE CARE UNIT	5,734	5,734	1,188,095	0	1,630,857	31.00
40.00	04000	SUBPROVIDER - IPF	12,607	12,607	3,689,721	0	4,594,732	40.00
43.00	04300	NURSERY	1,268	1,268	1,353,972	0	969,329	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	5,798	5,798	1,384,298	0	2,176,251	50.00
51.00	05100	RECOVERY ROOM	0	0	214,827	0	255,380	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,883	3,883	4,165,115	0	2,895,431	52.00
53.00	05300	ANESTHESIOLOGY	748	748	1,573,470	0	464,565	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,749	10,749	2,229,573	0	3,079,168	54.00
57.00	05700	CT SCAN	0	0	419,391	0	522,840	57.00
58.00	05800	MRI	0	0	163,366	0	194,575	58.00
60.00	06000	LABORATORY	7,129	7,129	1,602,819	0	3,845,011	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	9,935	0	186,072	63.00
65.00	06500	RESPIRATORY THERAPY	1,313	1,313	854,579	0	1,042,524	65.00
66.00	06600	PHYSICAL THERAPY	1,728	1,728	1,027,732	0	1,288,729	66.00
69.00	06900	ELECTROCARDIOLOGY	1,002	1,002	342,736	0	505,439	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	633	633	45,040	0	67,005	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	3,918,098	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	751,448	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	2,424,261	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	363,311	0	434,890	75.00
76.00	03951	HEMODIALYSIS	0	0	0	0	416,566	76.00
76.01	03952	DIABETES CENTER	0	0	0	0	0	76.01
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	6,042	6,042	2,796,000	0	4,736,588	90.00
90.01	09001	CHEMOTHERAPY	0	0	49,388	0	63,078	90.01
90.02	09002	KEDZIE CLINIC	0	0	420,186	0	584,819	90.02
90.03	09003	LITTLE VILLAGE CLINIC	0	0	519,659	0	1,245,444	90.03
91.00	09100	EMERGENCY	3,715	3,715	2,814,162	0	3,535,288	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
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)	193,311	193,311	58,703,633	-38,952,880	64,721,436	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	150	150	0	0	2,215	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	9,195	9,195	0	0	135,780	192.00
192.01	19201	OTHER NON-REIMBURSABLE	0	0	114,868	0	138,600	192.01
192.02	19202	NEPHROLOGY	0	0	594,732	0	1,506,229	192.02

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0095

Period:
From 07/01/2020
To 06/30/2021

Worksheet B-1

Date/Time Prepared:
11/29/2021 3:10 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliatio n	ADMINISTRATIV E & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)				
			1.00	2.00	4.00	5A	5.00	
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,992,561	0	6,971,971		38,952,880	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	14.766703	0.000000	0.117347		0.585720	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			11,769		976,630	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000198		0.014685	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: 14-0095

Period:
From 07/01/2020
To 06/30/2021

Worksheet B-1

Date/Time Prepared:
11/29/2021 3:10 pm

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	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	169,286				6.00
7.00	00700	OPERATION OF PLANT	24,988	144,298			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,533	3,533	29,328		8.00
9.00	00900	HOUSEKEEPING	1,819	1,819	0	138,946	9.00
10.00	01000	DIETARY	3,667	3,667	0	3,667	82,494 10.00
11.00	01100	CAFETERIA	5,078	5,078	0	5,078	0 11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0 12.00
13.00	01300	NURSING ADMINISTRATION	3,547	3,547	0	3,547	0 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,230	5,230	0	5,230	0 14.00
15.00	01500	PHARMACY	2,892	2,892	0	2,892	0 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,695	3,695	0	3,695	0 16.00
17.00	01700	SOCIAL SERVICE	998	998	0	998	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	0	0	0	0 22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0 23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	42,145	42,145	12,052	42,145	37,659 30.00
31.00	03100	INTENSIVE CARE UNIT	5,734	5,734	3,842	5,734	11,526 31.00
40.00	04000	SUBPROVIDER - IPF	12,607	12,607	11,103	12,607	33,309 40.00
43.00	04300	NURSERY	1,268	1,268	2,331	1,268	0 43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	5,798	5,798	0	5,798	0 50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,883	3,883	0	3,883	0 52.00
53.00	05300	ANESTHESIOLOGY	748	748	0	748	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,749	10,749	0	10,749	0 54.00
57.00	05700	CT SCAN	0	0	0	0	0 57.00
58.00	05800	MRI	0	0	0	0	0 58.00
60.00	06000	LABORATORY	7,129	7,129	0	7,129	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
65.00	06500	RESPIRATORY THERAPY	1,313	1,313	0	1,313	0 65.00
66.00	06600	PHYSICAL THERAPY	1,728	1,728	0	1,728	0 66.00
69.00	06900	ELECTROCARDIOLOGY	1,002	1,002	0	1,002	0 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	633	633	0	633	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
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0 75.00
76.00	03951	HEMODIALYSIS	0	0	0	0	0 76.00
76.01	03952	DIABETES CENTER	0	0	0	0	0 76.01
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	6,042	6,042	0	6,042	0 90.00
90.01	09001	CHEMOTHERAPY	0	0	0	0	0 90.01
90.02	09002	KEDZIE CLINIC	0	0	0	0	0 90.02
90.03	09003	LITTLE VILLAGE CLINIC	0	0	0	0	0 90.03
91.00	09100	EMERGENCY	3,715	3,715	0	3,715	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0 92.00
OTHER REIMBURSABLE COST CENTERS							
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)	159,941	134,953	29,328	129,601	82,494 118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	150	150	0	150	0 190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	9,195	9,195	0	9,195	0 192.00
192.01	19201	OTHER NON-REIMBURSABLE	0	0	0	0	0 192.01
192.02	19202	NEPHROLOGY	0	0	0	0	0 192.02
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0 194.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0095

Period:
From 07/01/2020
To 06/30/2021

Worksheet B-1

Date/Time Prepared:
11/29/2021 3:10 pm

Cost Center Description			MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			6.00	7.00	8.00	9.00	10.00	
202.00		Cost to be allocated (per Wkst. B, Part I)	3,260,992	6,922,475	320,276	2,355,960	2,946,570	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	19.263211	47.973465	10.920486	16.955940	35.718598	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	142,106	449,884	66,918	54,927	94,675	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.839443	3.117742	2.281710	0.395312	1.147659	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: 14-0095

Period:
From 07/01/2020
To 06/30/2021

Worksheet B-1

Date/Time Prepared:
11/29/2021 3:10 pm

Cost Center Description		CAFETERIA (PROD FTE'S)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (NURS DIRECT FTE)	CENTRAL SERVICES & SUPPLY (COSTED REQUI)	PHARMACY (COSTED REQUI)	
		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	50,044				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	2,282	0	31,406		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	671	0	0	4,797,534	14.00
15.00	01500	PHARMACY	1,927	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,161	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	1,258	0	0	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	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	1,114	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	8,548	0	8,548	0	30.00
31.00	03100	INTENSIVE CARE UNIT	2,711	0	2,711	0	31.00
40.00	04000	SUBPROVIDER - IPF	3,725	0	3,725	0	40.00
43.00	04300	NURSERY	1,256	0	1,256	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,728	0	1,728	0	50.00
51.00	05100	RECOVERY ROOM	209	0	209	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,416	0	4,416	0	52.00
53.00	05300	ANESTHESIOLOGY	604	0	604	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,361	0	0	0	54.00
57.00	05700	CT SCAN	375	0	0	0	57.00
58.00	05800	MRI	198	0	0	0	58.00
60.00	06000	LABORATORY	2,487	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.	116	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	1,142	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,547	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	541	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	79	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	3,918,098	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	751,448	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	477	0	477	0	75.00
76.00	03951	HEMODIALYSIS	0	0	0	0	76.00
76.01	03952	DIABETES CENTER	0	0	0	0	76.01
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	2,743	0	2,743	0	90.00
90.01	09001	CHEMOTHERAPY	99	0	99	0	90.01
90.02	09002	KEDZIE CLINIC	0	0	0	0	90.02
90.03	09003	LITTLE VILLAGE CLINIC	0	0	0	0	90.03
91.00	09100	EMERGENCY	4,890	0	4,890	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
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)	49,665	0	31,406	4,669,546	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
192.01	19201	OTHER NON-REIMBURSABLE	379	0	0	0	192.01
192.02	19202	NEPHROLOGY	0	0	0	127,988	192.02
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.00
200.00		Cross Foot Adjustments					200.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0095

Period:
From 07/01/2020
To 06/30/2021

Worksheet B-1

Date/Time Prepared:
11/29/2021 3:10 pm

Cost Center Description		CAFETERIA (PROD FTE'S)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATIO N (NURS DIRECT FTE)	CENTRAL SERVICES & SUPPLY (COSTED REQUI)	PHARMACY (COSTED REQUI)	
		11.00	12.00	13.00	14.00	15.00	
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	1,269,197	0	2,254,454	1,450,008	2,577,811	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	25.361622	0.000000	71.784181	0.302240	1.062932	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	104,960	0	90,359	110,655	80,816	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	2.097354	0.000000	2.877125	0.023065	0.033324	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: 14-0095

Period:
From 07/01/2020
To 06/30/2021

Worksheet B-1

Date/Time Prepared:
11/29/2021 3:10 pm

Cost Center Description			MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALA RY & 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	294,465,533					16.00
17.00	01700	SOCIAL SERVICE	0	29,328				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			1,000	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0				23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	31,663,261	12,052	0	0	400	30.00
31.00	03100	INTENSIVE CARE UNIT	13,826,539	3,842	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	18,128,436	11,103	0	0	0	40.00
43.00	04300	NURSERY	3,428,775	2,331	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	13,991,640	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	776,914	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,508,121	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	5,171,411	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	20,538,443	0	0	0	0	54.00
57.00	05700	CT SCAN	19,542,921	0	0	0	0	57.00
58.00	05800	MRI	2,292,997	0	0	0	0	58.00
60.00	06000	LABORATORY	29,796,713	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.	3,183,243	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	10,455,143	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	6,314,714	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	4,843,027	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,158,352	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,176,422	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,749,028	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	27,688,671	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	426,326	0	0	0	0	75.00
76.00	03951	HEMODIALYSIS	614,848	0	0	0	0	76.00
76.01	03952	DIABETES CENTER	0	0	0	0	0	76.01
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	16,170,324	0	0	0	200	90.00
90.01	09001	CHEMOTHERAPY	163,204	0	0	0	0	90.01
90.02	09002	KEDZIE CLINIC	3,588,918	0	0	0	0	90.02
90.03	09003	LITTLE VILLAGE CLINIC	3,250,909	0	0	0	0	90.03
91.00	09100	EMERGENCY	40,016,233	0	0	0	400	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
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)	294,465,533	29,328	0	0	1,000	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	OTHER NON-REIMBURSABLE	0	0	0	0	0	192.01
192.02	19202	NEPHROLOGY	0	0	0	0	0	192.02

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0095

Period:
From 07/01/2020
To 06/30/2021

Worksheet B-1

Date/Time Prepared:
11/29/2021 3:10 pm

Cost Center Description			MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALA RY & FRINGES APPRV (ASSIGNED TIME)	
			16.00	17.00	19.00	20.00	21.00	
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,452,672	2,868,394	0	0	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.008329	97.803942	0.000000	0.000000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	92,790	47,460	0	0	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000315	1.618249	0.000000	0.000000	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)				0		206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)				0.000000		207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0095

Period:
From 07/01/2020
To 06/30/2021

Worksheet B-1

Date/Time Prepared:
11/29/2021 3:10 pm

Cost Center Description			INTERNS & RESIDENTS	PARAMED ED PRGM (ASSIGNED TIME)		
			SERVICES-OTHE R PRGM COSTS APPRV (ASSIGNED TIME)			
			22.00			23.00
			GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00	
5.00	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	1,000		22.00	
23.00	02300	PARAMED ED PRGM-(SPECIFY)		0	23.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	400	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	31.00	
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	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	
57.00	05700	CT SCAN	0	0	57.00	
58.00	05800	MRI	0	0	58.00	
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	
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	0	73.00	
75.00	07500	ASC (NON-DISTINCT PART)	0	0	75.00	
76.00	03951	HEMODIALYSIS	0	0	76.00	
76.01	03952	DIABETES CENTER	0	0	76.01	
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	200	0	90.00	
90.01	09001	CHEMOTHERAPY	0	0	90.01	
90.02	09002	KEDZIE CLINIC	0	0	90.02	
90.03	09003	LITTLE VILLAGE CLINIC	0	0	90.03	
91.00	09100	EMERGENCY	400	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00	
OTHER REIMBURSABLE COST CENTERS						
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)		1,000	0	118.00	
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00	
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00	
192.01	19201	OTHER NON-REIMBURSABLE	0	0	192.01	
192.02	19202	NEPHROLOGY	0	0	192.02	

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0095

Period:
From 07/01/2020
To 06/30/2021Worksheet B-1
Date/Time Prepared:
11/29/2021 3:10 pm

Cost Center Description			INTERNS & RESIDENTS	PARAMED ED PRGM (ASSIGNED TIME)	
			SERVICES-OTHE R PRGM COSTS APPRV (ASSIGNED TIME)		
			22.00	23.00	
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.00
200.00		Cross Foot Adjustments			200.00
201.00		Negative Cost Centers			201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,933,917	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1,933.917000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	20,443	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	20.443000	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)		0	206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)		0.000000	207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0095

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/29/2021 3:10 pm

			Title XVIII	Hospital	PPS			
Cost Center Description			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	16,155,534		16,155,534	0	16,155,534	30.00
31.00	03100	INTENSIVE CARE UNIT	4,276,832		4,276,832	19,986	4,296,818	31.00
40.00	04000	SUBPROVIDER - IPF	11,257,152		11,257,152	1,817	11,258,969	40.00
43.00	04300	NURSERY	2,047,850		2,047,850	0	2,047,850	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,223,710		4,223,710	0	4,223,710	50.00
51.00	05100	RECOVERY ROOM	431,736		431,736	0	431,736	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,418,123		5,418,123	0	5,418,123	52.00
53.00	05300	ANESTHESIOLOGY	901,462		901,462	0	901,462	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,043,989		6,043,989	0	6,043,989	54.00
57.00	05700	CT SCAN	1,001,362		1,001,362	0	1,001,362	57.00
58.00	05800	MRI	332,661		332,661	0	332,661	58.00
60.00	06000	LABORATORY	7,008,571		7,008,571	0	7,008,571	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	324,513		324,513	0	324,513	63.00
65.00	06500	RESPIRATORY THERAPY	1,879,740	0	1,879,740	0	1,879,740	65.00
66.00	06600	PHYSICAL THERAPY	2,280,877	0	2,280,877	3,037	2,283,914	66.00
69.00	06900	ELECTROCARDIOLOGY	939,905		939,905	0	939,905	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	171,197		171,197	0	171,197	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,448,656		7,448,656	0	7,448,656	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,441,601		1,441,601	0	1,441,601	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,651,641		6,651,641	0	6,651,641	73.00
75.00	07500	ASC (NON-DISTINCT PART)	739,503		739,503	0	739,503	75.00
76.00	03951	HEMODIALYSIS	665,678		665,678	0	665,678	76.00
76.01	03952	DIABETES CENTER	0		0	0	0	76.01
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	8,420,748		8,420,748	20,211	8,440,959	90.00
90.01	09001	CHEMOTHERAPY	111,001		111,001	0	111,001	90.01
90.02	09002	KEDZIE CLINIC	957,251		957,251	0	957,251	90.02
90.03	09003	LITTLE VILLAGE CLINIC	2,002,002		2,002,002	0	2,002,002	90.03
91.00	09100	EMERGENCY	6,727,795		6,727,795	0	6,727,795	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3,311,254		3,311,254		3,311,254	92.00
OTHER REIMBURSABLE COST CENTERS								
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)	103,172,344	0	103,172,344	45,051	103,217,395	200.00
201.00		Less Observation Beds	3,311,254		3,311,254		3,311,254	201.00
202.00		Total (see instructions)	99,861,090	0	99,861,090	45,051	99,906,141	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES					Provider CCN:14-0095	Period: From 07/01/2020 To 06/30/2021	Worksheet C Part I Date/Time Prepared: 11/29/2021 3:10 pm		
					Title XVIII		Hospital	PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
			Inpatient	Outpatient	Total (col. 6 + col. 7)				
			6.00	7.00	8.00				9.00
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	25,051,480		25,051,480				30.00
31.00	03100	INTENSIVE CARE UNIT	13,826,539		13,826,539				31.00
40.00	04000	SUBPROVIDER - IPF	18,128,436		18,128,436				40.00
43.00	04300	NURSERY	3,428,775		3,428,775				43.00
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,197,252	10,794,388	13,991,640	0.301874	0.000000		50.00
51.00	05100	RECOVERY ROOM	237,668	539,246	776,914	0.555706	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,484,631	1,023,490	8,508,121	0.636818	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	2,243,607	2,927,804	5,171,411	0.174316	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,644,997	14,893,446	20,538,443	0.294277	0.000000		54.00
57.00	05700	CT SCAN	5,635,372	13,907,549	19,542,921	0.051239	0.000000		57.00
58.00	05800	MRI	676,579	1,616,418	2,292,997	0.145077	0.000000		58.00
60.00	06000	LABORATORY	11,964,751	17,831,962	29,796,713	0.235213	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.	2,619,187	564,056	3,183,243	0.101944	0.000000		63.00
65.00	06500	RESPIRATORY THERAPY	10,002,371	452,772	10,455,143	0.179791	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	1,028,202	5,286,512	6,314,714	0.361200	0.000000		66.00
69.00	06900	ELECTROCARDIOLOGY	1,942,493	2,900,534	4,843,027	0.194074	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	102,381	1,055,971	1,158,352	0.147794	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,988,240	2,188,182	6,176,422	1.205982	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,843,410	905,618	2,749,028	0.524404	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	20,195,953	7,492,718	27,688,671	0.240230	0.000000		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	426,326	426,326	1.734595	0.000000		75.00
76.00	03951	HEMODIALYSIS	569,030	45,818	614,848	1.082671	0.000000		76.00
76.01	03952	DIABETES CENTER	0	0	0	0.000000	0.000000		76.01
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	16,170,324	16,170,324	0.520753	0.000000		90.00
90.01	09001	CHEMOTHERAPY	107	163,097	163,204	0.680137	0.000000		90.01
90.02	09002	KEDZIE CLINIC	0	3,588,918	3,588,918	0.266724	0.000000		90.02
90.03	09003	LITTLE VILLAGE CLINIC	0	3,250,909	3,250,909	0.615828	0.000000		90.03
91.00	09100	EMERGENCY	7,641,365	32,374,868	40,016,233	0.168127	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	220,650	6,391,131	6,611,781	0.500811	0.000000		92.00
	OTHER REIMBURSABLE COST CENTERS								
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)	147,673,476	146,792,057	294,465,533				200.00
201.00		Less Observation Beds							201.00
202.00		Total (see instructions)	147,673,476	146,792,057	294,465,533				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0095	Period: From 07/01/2020 To 06/30/2021	Worksheet C Part I Date/Time Prepared: 11/29/2021 3:10 pm
			Title XVIII	Hospital	PPS
Cost Center Description			PPS Inpatient Ratio		
			11.00		
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.301874		50.00
51.00	05100	RECOVERY ROOM	0.555706		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.636818		52.00
53.00	05300	ANESTHESIOLOGY	0.174316		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.294277		54.00
57.00	05700	CT SCAN	0.051239		57.00
58.00	05800	MRI	0.145077		58.00
60.00	06000	LABORATORY	0.235213		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000		62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.101944		63.00
65.00	06500	RESPIRATORY THERAPY	0.179791		65.00
66.00	06600	PHYSICAL THERAPY	0.361681		66.00
69.00	06900	ELECTROCARDIOLOGY	0.194074		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.147794		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.205982		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.524404		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.240230		73.00
75.00	07500	ASC (NON-DISTINCT PART)	1.734595		75.00
76.00	03951	HEMODIALYSIS	1.082671		76.00
76.01	03952	DIABETES CENTER	0.000000		76.01
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	0.522003		90.00
90.01	09001	CHEMOTHERAPY	0.680137		90.01
90.02	09002	KEDZIE CLINIC	0.266724		90.02
90.03	09003	LITTLE VILLAGE CLINIC	0.615828		90.03
91.00	09100	EMERGENCY	0.168127		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.500811		92.00
OTHER REIMBURSABLE COST CENTERS					
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: 14-0095

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/29/2021 3:10 pm

		Title XIX		Hospital		Cost
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		
				Total Costs	RCE Disallowance	Total Costs
		1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	16,155,534		16,155,534	0	16,155,534
31.00	03100 INTENSIVE CARE UNIT	4,276,832		4,276,832	19,986	4,296,818
40.00	04000 SUBPROVIDER - IPF	11,257,152		11,257,152	1,817	11,258,969
43.00	04300 NURSERY	2,047,850		2,047,850	0	2,047,850
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	4,223,710		4,223,710	0	4,223,710
51.00	05100 RECOVERY ROOM	431,736		431,736	0	431,736
52.00	05200 DELIVERY ROOM & LABOR ROOM	5,418,123		5,418,123	0	5,418,123
53.00	05300 ANESTHESIOLOGY	901,462		901,462	0	901,462
54.00	05400 RADIOLOGY-DIAGNOSTIC	6,043,989		6,043,989	0	6,043,989
57.00	05700 CT SCAN	1,001,362		1,001,362	0	1,001,362
58.00	05800 MRI	332,661		332,661	0	332,661
60.00	06000 LABORATORY	7,008,571		7,008,571	0	7,008,571
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	324,513		324,513	0	324,513
65.00	06500 RESPIRATORY THERAPY	1,879,740	0	1,879,740	0	1,879,740
66.00	06600 PHYSICAL THERAPY	2,280,877	0	2,280,877	3,037	2,283,914
69.00	06900 ELECTROCARDIOLOGY	939,905		939,905	0	939,905
70.00	07000 ELECTROENCEPHALOGRAPHY	171,197		171,197	0	171,197
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	7,448,656		7,448,656	0	7,448,656
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1,441,601		1,441,601	0	1,441,601
73.00	07300 DRUGS CHARGED TO PATIENTS	6,651,641		6,651,641	0	6,651,641
75.00	07500 ASC (NON-DISTINCT PART)	739,503		739,503	0	739,503
76.00	03951 HEMODIALYSIS	665,678		665,678	0	665,678
76.01	03952 DIABETES CENTER	0		0	0	0
76.97	07697 CARDIAC REHABILITATION	0		0	0	0
76.98	07698 HYPERBARIC OXYGEN THERAPY	0		0	0	0
76.99	07699 LITHOTRIPSY	0		0	0	0
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	8,420,748		8,420,748	20,211	8,440,959
90.01	09001 CHEMOTHERAPY	111,001		111,001	0	111,001
90.02	09002 KEDZIE CLINIC	957,251		957,251	0	957,251
90.03	09003 LITTLE VILLAGE CLINIC	2,002,002		2,002,002	0	2,002,002
91.00	09100 EMERGENCY	6,727,795		6,727,795	0	6,727,795
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	3,311,254		3,311,254		3,311,254
OTHER REIMBURSABLE COST CENTERS						
99.20	09920 OUTPATIENT PHYSICAL THERAPY	0		0		0
99.30	09930 OUTPATIENT OCCUPATIONAL THERAPY	0		0		0
99.40	09940 OUTPATIENT SPEECH PATHOLOGY	0		0		0
200.00	Subtotal (see instructions)	103,172,344	0	103,172,344	45,051	103,217,395
201.00	Less Observation Beds	3,311,254		3,311,254		3,311,254
202.00	Total (see instructions)	99,861,090	0	99,861,090	45,051	99,906,141

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0095

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
11/29/2021 3:10 pm

			Title XIX		Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	25,051,480		25,051,480		30.00
31.00	03100	INTENSIVE CARE UNIT	13,826,539		13,826,539		31.00
40.00	04000	SUBPROVIDER - IPF	18,128,436		18,128,436		40.00
43.00	04300	NURSERY	3,428,775		3,428,775		43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,197,252	10,794,388	13,991,640	0.301874	0.000000
51.00	05100	RECOVERY ROOM	237,668	539,246	776,914	0.555706	0.000000
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,484,631	1,023,490	8,508,121	0.636818	0.000000
53.00	05300	ANESTHESIOLOGY	2,243,607	2,927,804	5,171,411	0.174316	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,644,997	14,893,446	20,538,443	0.294277	0.000000
57.00	05700	CT SCAN	5,635,372	13,907,549	19,542,921	0.051239	0.000000
58.00	05800	MRI	676,579	1,616,418	2,292,997	0.145077	0.000000
60.00	06000	LABORATORY	11,964,751	17,831,962	29,796,713	0.235213	0.000000
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,619,187	564,056	3,183,243	0.101944	0.000000
65.00	06500	RESPIRATORY THERAPY	10,002,371	452,772	10,455,143	0.179791	0.000000
66.00	06600	PHYSICAL THERAPY	1,028,202	5,286,512	6,314,714	0.361200	0.000000
69.00	06900	ELECTROCARDIOLOGY	1,942,493	2,900,534	4,843,027	0.194074	0.000000
70.00	07000	ELECTROENCEPHALOGRAPHY	102,381	1,055,971	1,158,352	0.147794	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,988,240	2,188,182	6,176,422	1.205982	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,843,410	905,618	2,749,028	0.524404	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	20,195,953	7,492,718	27,688,671	0.240230	0.000000
75.00	07500	ASC (NON-DISTINCT PART)	0	426,326	426,326	1.734595	0.000000
76.00	03951	HEMODIALYSIS	569,030	45,818	614,848	1.082671	0.000000
76.01	03952	DIABETES CENTER	0	0	0	0.000000	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	16,170,324	16,170,324	0.520753	0.000000
90.01	09001	CHEMOTHERAPY	107	163,097	163,204	0.680137	0.000000
90.02	09002	KEDZIE CLINIC	0	3,588,918	3,588,918	0.266724	0.000000
90.03	09003	LITTLE VILLAGE CLINIC	0	3,250,909	3,250,909	0.615828	0.000000
91.00	09100	EMERGENCY	7,641,365	32,374,868	40,016,233	0.168127	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	220,650	6,391,131	6,611,781	0.500811	0.000000
	OTHER REIMBURSABLE COST CENTERS						
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)	147,673,476	146,792,057	294,465,533		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	147,673,476	146,792,057	294,465,533		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN:14-0095	Period: From 07/01/2020 To 06/30/2021	Worksheet C Part I Date/Time Prepared: 11/29/2021 3:10 pm
			Title XIX	Hospital	Cost
Cost Center Description			PPS Inpatient Ratio		
			11.00		
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
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
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MRI	0.000000		58.00
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
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
75.00	07500	ASC (NON-DISTINCT PART)	0.000000		75.00
76.00	03951	HEMODIALYSIS	0.000000		76.00
76.01	03952	DIABETES CENTER	0.000000		76.01
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	09001	CHEMOTHERAPY	0.000000		90.01
90.02	09002	KEDZIE CLINIC	0.000000		90.02
90.03	09003	LITTLE VILLAGE CLINIC	0.000000		90.03
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS					
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: 14-0095

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part I
Date/Time Prepared:
11/29/2021 3:10 pm

Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Hospital Total Patient Days	PPS Per Diem (col. 3 / col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	1,031,440	0	1,031,440	15,159	68.04	30.00	
31.00	INTENSIVE CARE UNIT	179,867		179,867	3,842	46.82	31.00	
40.00	SUBPROVIDER - IPF	415,009	0	415,009	11,103	37.38	40.00	
43.00	NURSERY	55,164		55,164	2,331	23.67	43.00	
200.00	Total (lines 30 through 199)	1,681,480		1,681,480	32,435		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	1,774	120,703					30.00
31.00	INTENSIVE CARE UNIT	643	30,105					31.00
40.00	SUBPROVIDER - IPF	1,530	57,191					40.00
43.00	NURSERY	0	0					43.00
200.00	Total (lines 30 through 199)	3,947	207,999					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0095

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part II
Date/Time Prepared:
11/29/2021 3:10 pm

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	PPS	
						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	462,203	13,991,640	0.033034	307,927	10,172	50.00
51.00	05100 RECOVERY ROOM	5,077	776,914	0.006535	29,296	191	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	142,231	8,508,121	0.016717	0	0	52.00
53.00	05300 ANESTHESIOLOGY	26,071	5,171,411	0.005041	136,923	690	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	267,096	20,538,443	0.013005	1,208,976	15,723	54.00
57.00	05700 CT SCAN	14,704	19,542,921	0.000752	861,515	648	57.00
58.00	05800 MRI	4,026	2,292,997	0.001756	75,031	132	58.00
60.00	06000 LABORATORY	241,970	29,796,713	0.008121	1,527,207	12,402	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	3,980	3,183,243	0.001250	372,674	466	63.00
65.00	06500 RESPIRATORY THERAPY	46,270	10,455,143	0.004426	1,801,036	7,971	65.00
66.00	06600 PHYSICAL THERAPY	57,400	6,314,714	0.009090	226,315	2,057	66.00
69.00	06900 ELECTROCARDIOLOGY	29,308	4,843,027	0.006052	385,008	2,330	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	13,626	1,158,352	0.011763	20,094	236	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	149,854	6,176,422	0.024262	594,829	14,432	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	29,233	2,749,028	0.010634	308,076	3,276	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	125,107	27,688,671	0.004518	2,828,644	12,780	73.00
75.00	07500 ASC (NON-DISTINCT PART)	8,964	426,326	0.021026	0	0	75.00
76.00	03951 HEMODIALYSIS	6,311	614,848	0.010264	181,794	1,866	76.00
76.01	03952 DIABETES CENTER	0	0	0.000000	0	0	76.01
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	437,959	16,170,324	0.027084	0	0	90.00
90.01	09001 CHEMOTHERAPY	1,480	163,204	0.009068	0	0	90.01
90.02	09002 KEDZIE CLINIC	9,802	3,588,918	0.002731	0	0	90.02
90.03	09003 LITTLE VILLAGE CLINIC	470,880	3,250,909	0.144846	0	0	90.03
91.00	09100 EMERGENCY	168,354	40,016,233	0.004207	1,005,043	4,228	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	211,404	6,611,781	0.031974	0	0	92.00
200.00	Total (lines 50 through 199)	2,933,310	234,030,303		11,870,388	89,600	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN:14-0095		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part III Date/Time Prepared: 11/29/2021 3:10 pm		
					Title XVIII		Hospital		PPS		
Cost Center Description			Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost				
			1A	1.00	2A	2.00	3.00				
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00			
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00			
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00			
43.00	04300	NURSERY	0	0	0	0	0	43.00			
200.00		Total (lines 30 through 199)	0	0	0	0	0	200.00			
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days				
			4.00	5.00	6.00	7.00	8.00				
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	15,159	0.00	1,774	30.00			
31.00	03100	INTENSIVE CARE UNIT	0	0	3,842	0.00	643	31.00			
40.00	04000	SUBPROVIDER - IPF	0	0	11,103	0.00	1,530	40.00			
43.00	04300	NURSERY	0	0	2,331	0.00	0	43.00			
200.00		Total (lines 30 through 199)	0	0	32,435		3,947	200.00			
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)								
			9.00								
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0								30.00
31.00	03100	INTENSIVE CARE UNIT	0								31.00
40.00	04000	SUBPROVIDER - IPF	0								40.00
43.00	04300	NURSERY	0								43.00
200.00		Total (lines 30 through 199)	0								200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0095		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part IV Date/Time Prepared: 11/29/2021 3:10 pm	
			Title XVIII		Hospital		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	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
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
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	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
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03951	HEMODIALYSIS	0	0	0	0	0	76.00
76.01	03952	DIABETES CENTER	0	0	0	0	0	76.01
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	09001	CHEMOTHERAPY	0	0	0	0	0	90.01
90.02	09002	KEDZIE CLINIC	0	0	0	0	0	90.02
90.03	09003	LITTLE VILLAGE CLINIC	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0095

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part IV
Date/Time Prepared:
11/29/2021 3:10 pm

			Title XVIII		Hospital	PPS		
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	13,991,640	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	776,914	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	8,508,121	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	5,171,411	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	20,538,443	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	19,542,921	0.000000	57.00
58.00	05800	MRI	0	0	0	2,292,997	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	29,796,713	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	3,183,243	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	10,455,143	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	6,314,714	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	4,843,027	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	1,158,352	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	6,176,422	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	2,749,028	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	27,688,671	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	426,326	0.000000	75.00
76.00	03951	HEMODIALYSIS	0	0	0	614,848	0.000000	76.00
76.01	03952	DIABETES CENTER	0	0	0	0	0.000000	76.01
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	16,170,324	0.000000	90.00
90.01	09001	CHEMOTHERAPY	0	0	0	163,204	0.000000	90.01
90.02	09002	KEDZIE CLINIC	0	0	0	3,588,918	0.000000	90.02
90.03	09003	LITTLE VILLAGE CLINIC	0	0	0	3,250,909	0.000000	90.03
91.00	09100	EMERGENCY	0	0	0	40,016,233	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	6,611,781	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	234,030,303		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0095		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part IV Date/Time Prepared: 11/29/2021 3:10 pm	
				Title XVIII		Hospital		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0.000000	307,927	0	686,174	0	50.00
51.00	05100	RECOVERY ROOM		0.000000	29,296	0	37,294	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0.000000	136,923	0	212,453	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.000000	1,208,976	0	1,407,351	0	54.00
57.00	05700	CT SCAN		0.000000	861,515	0	1,039,810	0	57.00
58.00	05800	MRI		0.000000	75,031	0	200,882	0	58.00
60.00	06000	LABORATORY		0.000000	1,527,207	0	682,661	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	372,674	0	9,065	0	63.00
65.00	06500	RESPIRATORY THERAPY		0.000000	1,801,036	0	36,566	0	65.00
66.00	06600	PHYSICAL THERAPY		0.000000	226,315	0	15,634	0	66.00
69.00	06900	ELECTROCARDIOLOGY		0.000000	385,008	0	301,880	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0.000000	20,094	0	159,494	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.000000	594,829	0	181,434	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0.000000	308,076	0	151,714	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.000000	2,828,644	0	456,940	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)		0.000000	0	0	42,031	0	75.00
76.00	03951	HEMODIALYSIS		0.000000	181,794	0	14,780	0	76.00
76.01	03952	DIABETES CENTER		0.000000	0	0	0	0	76.01
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	1,923,362	0	90.00
90.01	09001	CHEMOTHERAPY		0.000000	0	0	61,757	0	90.01
90.02	09002	KEDZIE CLINIC		0.000000	0	0	738	0	90.02
90.03	09003	LITTLE VILLAGE CLINIC		0.000000	0	0	13,222	0	90.03
91.00	09100	EMERGENCY		0.000000	1,005,043	0	1,387,719	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0.000000	0	0	296,510	0	92.00
200.00		Total (lines 50 through 199)			11,870,388	0	9,319,471	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 14-0095		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part V Date/Time Prepared: 11/29/2021 3:10 pm	
				Title XVIII		Hospital		PPS	
Cost Center Description				Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
					PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
				1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0.301874	686,174	0	0	207,138	50.00
51.00	05100	RECOVERY ROOM		0.555706	37,294	0	0	20,724	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0.636818	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0.174316	212,453	0	0	37,034	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.294277	1,407,351	0	0	414,151	54.00
57.00	05700	CT SCAN		0.051239	1,039,810	0	0	53,279	57.00
58.00	05800	MRI		0.145077	200,882	0	0	29,143	58.00
60.00	06000	LABORATORY		0.235213	682,661	2,034	0	160,571	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS		0.000000	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.		0.101944	9,065	0	0	924	63.00
65.00	06500	RESPIRATORY THERAPY		0.179791	36,566	0	0	6,574	65.00
66.00	06600	PHYSICAL THERAPY		0.361200	15,634	0	0	5,647	66.00
69.00	06900	ELECTROCARDIOLOGY		0.194074	301,880	0	0	58,587	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0.147794	159,494	0	0	23,572	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		1.205982	181,434	0	0	218,806	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0.524404	151,714	0	0	79,559	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.240230	456,940	0	34,974	109,771	73.00
75.00	07500	ASC (NON-DISTINCT PART)		1.734595	42,031	0	0	72,907	75.00
76.00	03951	HEMODIALYSIS		1.082671	14,780	0	0	16,002	76.00
76.01	03952	DIABETES CENTER		0.000000	0	0	0	0	76.01
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		0.520753	1,923,362	0	551	1,001,597	90.00
90.01	09001	CHEMOTHERAPY		0.680137	61,757	0	0	42,003	90.01
90.02	09002	KEDZIE CLINIC		0.266724	738	0	0	197	90.02
90.03	09003	LITTLE VILLAGE CLINIC		0.615828	13,222	0	0	8,142	90.03
91.00	09100	EMERGENCY		0.168127	1,387,719	0	0	233,313	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0.500811	296,510	0	0	148,495	92.00
200.00		Subtotal (see instructions)			9,319,471	2,034	35,525	2,948,136	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges				0	0		201.00
202.00		Net Charges (line 200 - line 201)			9,319,471	2,034	35,525	2,948,136	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN:14-0095		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part V Date/Time Prepared: 11/29/2021 3:10 pm	
				Title XVIII		Hospital		PPS	
Cost Center Description			Costs						
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)					
			6.00	7.00					
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0					50.00
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
57.00	05700	CT SCAN	0	0					57.00
58.00	05800	MRI	0	0					58.00
60.00	06000	LABORATORY	478	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
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	8,402					73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0					75.00
76.00	03951	HEMODIALYSIS	0	0					76.00
76.01	03952	DIABETES CENTER	0	0					76.01
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	287					90.00
90.01	09001	CHEMOTHERAPY	0	0					90.01
90.02	09002	KEDZIE CLINIC	0	0					90.02
90.03	09003	LITTLE VILLAGE CLINIC	0	0					90.03
91.00	09100	EMERGENCY	0	0					91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0					92.00
200.00		Subtotal (see instructions)	478	8,689					200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0						201.00
202.00		Net Charges (line 200 - line 201)	478	8,689					202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN:14-0095	Period: From 07/01/2020 To 06/30/2021	Worksheet D Part II Date/Time Prepared: 11/29/2021 3:10 pm		
				Component CCN:14-S095				
				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	462,203	13,991,640	0.033034	0	0	50.00
51.00	05100	RECOVERY ROOM	5,077	776,914	0.006535	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	142,231	8,508,121	0.016717	0	0	52.00
53.00	05300	ANESTHESIOLOGY	26,071	5,171,411	0.005041	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	267,096	20,538,443	0.013005	14,619	190	54.00
57.00	05700	CT SCAN	14,704	19,542,921	0.000752	15,224	11	57.00
58.00	05800	MRI	4,026	2,292,997	0.001756	6,201	11	58.00
60.00	06000	LABORATORY	241,970	29,796,713	0.008121	159,637	1,296	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	3,980	3,183,243	0.001250	3,890	5	63.00
65.00	06500	RESPIRATORY THERAPY	46,270	10,455,143	0.004426	27,379	121	65.00
66.00	06600	PHYSICAL THERAPY	57,400	6,314,714	0.009090	1,285	12	66.00
69.00	06900	ELECTROCARDIOLOGY	29,308	4,843,027	0.006052	8,846	54	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	13,626	1,158,352	0.011763	3,225	38	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	149,854	6,176,422	0.024262	1,164	28	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	29,233	2,749,028	0.010634	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	125,107	27,688,671	0.004518	201,907	912	73.00
75.00	07500	ASC (NON-DISTINCT PART)	8,964	426,326	0.021026	0	0	75.00
76.00	03951	HEMODIALYSIS	6,311	614,848	0.010264	0	0	76.00
76.01	03952	DIABETES CENTER	0	0	0.000000	0	0	76.01
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	437,959	16,170,324	0.027084	0	0	90.00
90.01	09001	CHEMOTHERAPY	1,480	163,204	0.009068	0	0	90.01
90.02	09002	KEDZIE CLINIC	9,802	3,588,918	0.002731	0	0	90.02
90.03	09003	LITTLE VILLAGE CLINIC	470,880	3,250,909	0.144846	0	0	90.03
91.00	09100	EMERGENCY	168,354	40,016,233	0.004207	126,047	530	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	6,611,781	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	2,721,906	234,030,303		569,424	3,208	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN:14-0095 Component CCN:14-S095		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part IV Date/Time Prepared: 11/29/2021 3:10 pm	
				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	0	50.00
51.00	05100	RECOVERY ROOM		0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0	54.00
57.00	05700	CT SCAN		0	0	0	0	0	57.00
58.00	05800	MRI		0	0	0	0	0	58.00
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
65.00	06500	RESPIRATORY THERAPY		0	0	0	0	0	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
75.00	07500	ASC (NON-DISTINCT PART)		0	0	0	0	0	75.00
76.00	03951	HEMODIALYSIS		0	0	0	0	0	76.00
76.01	03952	DIABETES CENTER		0	0	0	0	0	76.01
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	09001	CHEMOTHERAPY		0	0	0	0	0	90.01
90.02	09002	KEDZIE CLINIC		0	0	0	0	0	90.02
90.03	09003	LITTLE VILLAGE CLINIC		0	0	0	0	0	90.03
91.00	09100	EMERGENCY		0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN:14-0095 Component CCN:14-S095		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part IV Date/Time Prepared: 11/29/2021 3:10 pm	
				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	0	0	13,991,640	0.000000	50.00
51.00	05100	RECOVERY ROOM		0	0	0	776,914	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	8,508,121	0.000000	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	5,171,411	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	20,538,443	0.000000	54.00
57.00	05700	CT SCAN		0	0	0	19,542,921	0.000000	57.00
58.00	05800	MRI		0	0	0	2,292,997	0.000000	58.00
60.00	06000	LABORATORY		0	0	0	29,796,713	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	3,183,243	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	10,455,143	0.000000	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	6,314,714	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	4,843,027	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	1,158,352	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	6,176,422	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	2,749,028	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	27,688,671	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)		0	0	0	426,326	0.000000	75.00
76.00	03951	HEMODIALYSIS		0	0	0	614,848	0.000000	76.00
76.01	03952	DIABETES CENTER		0	0	0	0	0.000000	76.01
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	16,170,324	0.000000	90.00
90.01	09001	CHEMOTHERAPY		0	0	0	163,204	0.000000	90.01
90.02	09002	KEDZIE CLINIC		0	0	0	3,588,918	0.000000	90.02
90.03	09003	LITTLE VILLAGE CLINIC		0	0	0	3,250,909	0.000000	90.03
91.00	09100	EMERGENCY		0	0	0	40,016,233	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	6,611,781	0.000000	92.00
200.00		Total (lines 50 through 199)		0	0	0	234,030,303		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN:14-0095 Component CCN:14-S095		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part IV Date/Time Prepared: 11/29/2021 3:10 pm	
				Title XVIII		Subprovider - IPF		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	0.000000	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	14,619	0	383	0	0	54.00
57.00	05700	CT SCAN	0.000000	15,224	0	0	0	0	57.00
58.00	05800	MRI	0.000000	6,201	0	0	0	0	58.00
60.00	06000	LABORATORY	0.000000	159,637	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	3,890	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	27,379	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	1,285	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	8,846	0	196	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	3,225	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	1,164	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	201,907	0	331	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	0	0	0	0	0	75.00
76.00	03951	HEMODIALYSIS	0.000000	0	0	0	0	0	76.00
76.01	03952	DIABETES CENTER	0.000000	0	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0.000000	0	0	0	0	0	90.00
90.01	09001	CHEMOTHERAPY	0.000000	0	0	0	0	0	90.01
90.02	09002	KEDZIE CLINIC	0.000000	0	0	0	0	0	90.02
90.03	09003	LITTLE VILLAGE CLINIC	0.000000	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.000000	126,047	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		569,424	0	910	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN:14-0095		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part V Date/Time Prepared: 11/29/2021 3:10 pm	
				Component CCN:14-S095					
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
			1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0.301874	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.555706	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.636818	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.174316	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.294277	383	0	0	0	113	54.00
57.00	05700	CT SCAN	0.051239	0	0	0	0	0	57.00
58.00	05800	MRI	0.145077	0	0	0	0	0	58.00
60.00	06000	LABORATORY	0.235213	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.	0.101944	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.179791	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.361200	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.194074	196	0	0	0	38	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.147794	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.205982	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.524404	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.240230	331	0	0	0	80	73.00
75.00	07500	ASC (NON-DISTINCT PART)	1.734595	0	0	0	0	0	75.00
76.00	03951	HEMODIALYSIS	1.082671	0	0	0	0	0	76.00
76.01	03952	DIABETES CENTER	0.000000	0	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0.520753	0	0	0	0	0	90.00
90.01	09001	CHEMOTHERAPY	0.680137	0	0	0	0	0	90.01
90.02	09002	KEDZIE CLINIC	0.266724	0	0	0	0	0	90.02
90.03	09003	LITTLE VILLAGE CLINIC	0.615828	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.168127	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.500811	0	0	0	0	0	92.00
200.00		Subtotal (see instructions)		910	0	0	0	231	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0	0		201.00
202.00		Net Charges (line 200 - line 201)		910	0	0	0	231	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN:14-0095	Period: From 07/01/2020	Worksheet D
		Component CCN:14-S095	To 06/30/2021	Part V
		Title XVIII	Subprovider - IPF	Date/Time Prepared: 11/29/2021 3:10 pm
				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
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	0	0	58.00
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
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	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	75.00
76.00	03951	HEMODIALYSIS	0	0	76.00
76.01	03952	DIABETES CENTER	0	0	76.01
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	09001	CHEMOTHERAPY	0	0	90.01
90.02	09002	KEDZIE CLINIC	0	0	90.02
90.03	09003	LITTLE VILLAGE CLINIC	0	0	90.03
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
200.00		Subtotal (see instructions)	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	0	202.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0095

Period:
From 07/01/2020
To 06/30/2021

Worksheet D-1

Date/Time Prepared:
11/29/2021 3:10 pm

Title XVIII		Hospital	PPS
Cost Center Description			1.00
PART I - ALL PROVIDER COMPONENTS			
INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	15,159	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	15,159	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)	12,052	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	1,774	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)	16,155,534	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)	16,155,534	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)	16,155,534	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)	1,065.74	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,890,623	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,890,623	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0095

Period:
From 07/01/2020
To 06/30/2021

Worksheet D-1

Date/Time Prepared:
11/29/2021 3:10 pm

		Title XVIII		Hospital		PPS	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	4,296,818	3,842	1,118.38	643	719,118	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
							1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					3,348,702	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					5,958,443	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)					150,808	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					89,600	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					240,408	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					5,718,035	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)					3,107	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,065.74	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					3,311,254	89.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN:14-0095		Period: From 07/01/2020 To 06/30/2021		Worksheet D-1 Date/Time Prepared: 11/29/2021 3:10 pm		
				Title XVIII		Hospital		PPS		
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)				
		1.00	2.00	3.00	4.00	5.00				
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST									
90.00	Capital-related cost	1,031,440	16,155,534	0.063844	3,311,254	211,404	90.00			
91.00	Nursing School cost	0	16,155,534	0.000000	3,311,254	0	91.00			
92.00	Allied health cost	0	16,155,534	0.000000	3,311,254	0	92.00			
93.00	All other Medical Education	0	16,155,534	0.000000	3,311,254	0	93.00			

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0095 Component CCN: 14-S095	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Prepared: 11/29/2021 3:10 pm
		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)		11,103	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		11,103	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)		11,103	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		1,530	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)		11,258,969	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)		11,258,969	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)		11,258,969	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)		1,014.05	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,551,497	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,551,497	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0095	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1	
				Component CCN: 14-S095		Date/Time Prepared: 11/29/2021 3:10 pm	
				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	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
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)					122,609	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,674,106	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)					57,191	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					3,208	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					60,399	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					1,613,707	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: 14-0095 Component CCN: 14-S095		Period: From 07/01/2020 To 06/30/2021		Worksheet D-1 Date/Time Prepared: 11/29/2021 3:10 pm	
		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	415,009	11,258,969	0.036860	0	0	90.00
91.00	Nursing School cost	0	11,258,969	0.000000	0	0	91.00
92.00	Allied health cost	0	11,258,969	0.000000	0	0	92.00
93.00	All other Medical Education	0	11,258,969	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0095	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Prepared: 11/29/2021 3:10 pm
Cost Center Description		Title XIX	Hospital	Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		15,159	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		15,159	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)		12,052	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		1,278	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)		2,331	15.00
16.00	Nursery days (title V or XIX only)		526	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)		16,155,534	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)		16,155,534	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)		16,155,534	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)		1,065.74	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,362,016	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,362,016	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0095

Period:
From 07/01/2020
To 06/30/2021

Worksheet D-1

Date/Time Prepared:
11/29/2021 3:10 pm

Cost Center Description		Title XIX		Hospital		Cost	
		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)	2,047,850	2,331	878.53	526	462,107	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	4,276,832	3,842	1,113.18	557	620,041	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					3,392,669	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					5,836,833	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)					3,107	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,065.74	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					3,311,254	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0095

Period:
From 07/01/2020
To 06/30/2021

Worksheet D-1

Date/Time Prepared:
11/29/2021 3:10 pm

		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	1,031,440	16,155,534	0.063844	3,311,254	211,404
91.00	Nursing School cost	0	16,155,534	0.000000	3,311,254	0
92.00	Allied health cost	0	16,155,534	0.000000	3,311,254	0
93.00	All other Medical Education	0	16,155,534	0.000000	3,311,254	0

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0095	Period: From 07/01/2020 To 06/30/2021	Worksheet D-3 Date/Time Prepared: 11/29/2021 3:10 pm	
			Title XVIII	Hospital	PPS	
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		3,673,508		30.00
31.00	03100	INTENSIVE CARE UNIT		2,235,192		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.301874	307,927	92,955	50.00
51.00	05100	RECOVERY ROOM	0.555706	29,296	16,280	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.636818	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.174316	136,923	23,868	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.294277	1,208,976	355,774	54.00
57.00	05700	CT SCAN	0.051239	861,515	44,143	57.00
58.00	05800	MRI	0.145077	75,031	10,885	58.00
60.00	06000	LABORATORY	0.235213	1,527,207	359,219	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.101944	372,674	37,992	63.00
65.00	06500	RESPIRATORY THERAPY	0.179791	1,801,036	323,810	65.00
66.00	06600	PHYSICAL THERAPY	0.361681	226,315	81,854	66.00
69.00	06900	ELECTROCARDIOLOGY	0.194074	385,008	74,720	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.147794	20,094	2,970	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.205982	594,829	717,353	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.524404	308,076	161,556	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.240230	2,828,644	679,525	73.00
75.00	07500	ASC (NON-DISTINCT PART)	1.734595	0	0	75.00
76.00	03951	HEMODIALYSIS	1.082671	181,794	196,823	76.00
76.01	03952	DIABETES CENTER	0.000000	0	0	76.01
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	0.522003	0	0	90.00
90.01	09001	CHEMOTHERAPY	0.680137	0	0	90.01
90.02	09002	KEDZIE CLINIC	0.266724	0	0	90.02
90.03	09003	LITTLE VILLAGE CLINIC	0.615828	0	0	90.03
91.00	09100	EMERGENCY	0.168127	1,005,043	168,975	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.500811	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		11,870,388	3,348,702	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)		11,870,388		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN:14-0095	Period: From 07/01/2020 To 06/30/2021	Worksheet D-3 Date/Time Prepared: 11/29/2021 3:10 pm	
		Component CCN:14-S095			
		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				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
40.00	04000 SUBPROVIDER - IPF		2,463,641		40.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.301874	0	0	50.00
51.00	05100 RECOVERY ROOM	0.555706	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.636818	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.174316	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.294277	14,619	4,302	54.00
57.00	05700 CT SCAN	0.051239	15,224	780	57.00
58.00	05800 MRI	0.145077	6,201	900	58.00
60.00	06000 LABORATORY	0.235213	159,637	37,549	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.101944	3,890	397	63.00
65.00	06500 RESPIRATORY THERAPY	0.179791	27,379	4,922	65.00
66.00	06600 PHYSICAL THERAPY	0.361681	1,285	465	66.00
69.00	06900 ELECTROCARDIOLOGY	0.194074	8,846	1,717	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.147794	3,225	477	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1.205982	1,164	1,404	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.524404	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.240230	201,907	48,504	73.00
75.00	07500 ASC (NON-DISTINCT PART)	1.734595	0	0	75.00
76.00	03951 HEMODIALYSIS	1.082671	0	0	76.00
76.01	03952 DIABETES CENTER	0.000000	0	0	76.01
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	0.522003	0	0	90.00
90.01	09001 CHEMOTHERAPY	0.680137	0	0	90.01
90.02	09002 KEDZIE CLINIC	0.266724	0	0	90.02
90.03	09003 LITTLE VILLAGE CLINIC	0.615828	0	0	90.03
91.00	09100 EMERGENCY	0.168127	126,047	21,192	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.500811	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		569,424	122,609	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)		569,424		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0095	Period: From 07/01/2020 To 06/30/2021	Worksheet D-3 Date/Time Prepared: 11/29/2021 3:10 pm	
			Title XIX	Hospital	Cost	
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		2,696,292		30.00
31.00	03100	INTENSIVE CARE UNIT		1,888,065		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
43.00	04300	NURSERY		685,095		43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.301874	451,464	136,285	50.00
51.00	05100	RECOVERY ROOM	0.555706	37,762	20,985	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.636818	918,184	584,716	52.00
53.00	05300	ANESTHESIOLOGY	0.174316	329,970	57,519	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.294277	342,547	100,804	54.00
57.00	05700	CT SCAN	0.051239	674,002	34,535	57.00
58.00	05800	MRI	0.145077	84,694	12,287	58.00
60.00	06000	LABORATORY	0.235213	1,821,702	428,488	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.101944	386,499	39,401	63.00
65.00	06500	RESPIRATORY THERAPY	0.179791	975,741	175,429	65.00
66.00	06600	PHYSICAL THERAPY	0.361200	81,122	29,301	66.00
69.00	06900	ELECTROCARDIOLOGY	0.194074	199,923	38,800	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.147794	2,064	305	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.205982	750,211	904,741	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.524404	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.240230	3,091,411	742,650	73.00
75.00	07500	ASC (NON-DISTINCT PART)	1.734595	0	0	75.00
76.00	03951	HEMODIALYSIS	1.082671	35,472	38,405	76.00
76.01	03952	DIABETES CENTER	0.000000	0	0	76.01
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	0.520753	0	0	90.00
90.01	09001	CHEMOTHERAPY	0.680137	0	0	90.01
90.02	09002	KEDZIE CLINIC	0.266724	0	0	90.02
90.03	09003	LITTLE VILLAGE CLINIC	0.615828	0	0	90.03
91.00	09100	EMERGENCY	0.168127	39,813	6,694	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.500811	82,514	41,324	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		10,305,095	3,392,669	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)		10,305,095		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0095	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part A Date/Time Prepared: 11/29/2021 3:10 pm
		Title XVIII	Hospital	PPS
			1.00	
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		741,397	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		3,133,627	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)		13,671	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)		219,522	2.04
3.00	Managed Care Simulated Payments		51,037	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		99.90	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)		5.59	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)		2.33	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.		1.17	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)		2.09	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		4.14	10.00
11.00	FTE count for residents in dental and podiatric programs.		1.64	11.00
12.00	Current year allowable FTE (see instructions)		3.73	12.00
13.00	Total allowable FTE count for the prior year.		3.72	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.		3.65	14.00
15.00	Sum of lines 12 through 14 divided by 3.		3.70	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		3.70	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.037037	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.035759	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.035759	21.00
22.00	IME payment adjustment (see instructions)		74,970	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		987	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)		2.05	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)		74,970	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		987	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		15.32	30.00
31.00	Percentage of Medicaid patient days (see instructions)		53.14	31.00
32.00	Sum of lines 30 and 31		68.46	32.00
33.00	Allowable disproportionate share percentage (see instructions)		12.00	33.00
34.00	Disproportionate share adjustment (see instructions)		116,251	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0095	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part A Date/Time Prepared: 11/29/2021 3:10 pm	
		Title XVIII	Hospital	PPS	
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)		0	0	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000		35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	1,837,177	1,641,249		35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	461,804	1,227,564		35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,689,368			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)	5,988,806			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)		5,989,793		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		298,644		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).		59,439		52.00
53.00	Nursing and Allied Health Managed Care payment		0		53.00
54.00	Special add-on payments for new technologies		78,936		54.00
54.01	Islet isolation add-on payment		0		54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0		55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0		56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0		57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0		58.00
59.00	Total (sum of amounts on lines 49 through 58)		6,426,812		59.00
60.00	Primary payer payments		9,261		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		6,417,551		61.00
62.00	Deductibles billed to program beneficiaries		361,348		62.00
63.00	Coinsurance billed to program beneficiaries		23,260		63.00
64.00	Allowable bad debts (see instructions)		335,500		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		218,075		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		210,677		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		6,251,018		67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0		68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0		69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)		0		70.50
70.87	Demonstration payment adjustment amount before sequestration		0		70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0		70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)				70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0		70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0		70.91
70.92	Bundled Model 1 discount amount (see instructions)		0		70.92
70.93	HVBP payment adjustment amount (see instructions)		33,670		70.93
70.94	HRR adjustment amount (see instructions)		-8,056		70.94
70.95	Recovery of accelerated depreciation		0		70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0095	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part A Date/Time Prepared: 11/29/2021 3:10 pm	
		Title XVIII	Hospital	PPS	
		FFY (yyyy)	Amount		
		0	1.00		
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96	
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97	
70.98	Low Volume Payment-3		0	70.98	
70.99	HAC adjustment amount (see instructions)		0	70.99	
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		6,276,632	71.00	
71.01	Sequestration adjustment (see instructions)		0	71.01	
71.02	Demonstration payment adjustment amount after sequestration		0	71.02	
71.03	Sequestration adjustment-PARHM pass-throughs		0	71.03	
72.00	Interim payments		5,903,614	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)		373,018	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		129,765	75.00	
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00	
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00	
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00	
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00	
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00	
95.00	Time value of money for operating expenses (see instructions)		0	95.00	
96.00	Time value of money for capital related expenses (see instructions)		0	96.00	
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)		0	0	100.00
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)		0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	0	102.00
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)		0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	0	104.00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)				201.00
202.00	Medicare discharges (see instructions)				202.00
203.00	Case-mix adjustment factor (see instructions)				203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
204.00	Medicare target amount				204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)				205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)				206.00
Adjustment to Medicare Part A Inpatient Reimbursement					
207.00	Program reimbursement under the §410A Demonstration (see instructions)				207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)				208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)				211.00
Comparison of PPS versus Cost Reimbursement					
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)				212.00
213.00	Low-volume adjustment (see instructions)				213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)				218.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0095

Period:
From 07/01/2020
To 06/30/2021Worksheet E
Part A Exhibit 4
Date/Time Prepared:
11/29/2021 3:10 pm

		Title XVIII		Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)
		0	1.00	2.00	3.00	4.00	5.00
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	741,397	0	741,397		741,397
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	3,133,627	0		3,133,627	3,133,627
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0
2.00	Outlier payments for discharges (see instructions)	2.00					
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	13,671	0	13,671		13,671
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	219,522	0		219,522	219,522
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0
4.00	Managed care simulated payments	3.00	51,037	0	0	51,037	51,037
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.035759	0.035759	0.035759	0.035759	
6.00	IME payment adjustment (see instructions)	22.00	74,970	0	14,344	60,626	74,970
6.01	IME payment adjustment for managed care (see instructions)	22.01	987	0	0	987	987
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000	
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0
9.00	Total IME payment (sum of lines 6 and 8)	29.00	74,970	0	14,344	60,626	74,970
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	987	0	0	987	987
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1200	0.1200	0.1200	0.1200	
11.00	Disproportionate share adjustment (see instructions)	34.00	116,251	0	22,242	94,009	116,251
11.01	Uncompensated care payments	36.00	1,689,368	0	461,804	1,227,564	1,689,368
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0
13.00	Subtotal (see instructions)	47.00	5,988,806	0	1,253,458	4,735,348	5,988,806
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0
15.00	Total payment for inpatient operating costs (see instructions)	49.00	5,989,793	0	1,253,458	4,736,335	5,989,793

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0095

Period:
From 07/01/2020
To 06/30/2021Worksheet E
Part A Exhibit 4
Date/Time Prepared:
11/29/2021 3:10 pm

		Title XVIII		Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)
		0	1.00	2.00	3.00	4.00	5.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	298,644	0	59,623	239,021	298,644
17.00	Special add-on payments for new technologies	54.00	78,936	0	0	78,936	78,936
17.01	Net organ aquisition cost						
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0
19.00	SUBTOTAL			0	1,313,081	5,054,292	6,367,373
		W/S L, line	(Amounts from L)				
		0	1.00	2.00	3.00	4.00	5.00
20.00	Capital DRG other than outlier	1.00	289,619	0	58,231	231,388	289,619
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0
21.00	Capital DRG outlier payments	2.00	2,103	0	0	2,103	2,103
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0
22.00	Indirect medical education percentage (see instructions)	5.00	0.0239	0.0239	0.0239	0.0239	
23.00	Indirect medical education adjustment (see instructions)	6.00	6,922	0	1,392	5,530	6,922
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000	
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0
26.00	Total prospective capital payments (see instructions)	12.00	298,644	0	59,623	239,021	298,644
		W/S E, Part A line	(Amounts to E, Part A)				
		0	1.00	2.00	3.00	4.00	5.00
27.00	Low volume adjustment factor				0.000000	0.000000	
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y				

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5			Provider CCN: 14-0095		Period: From 07/01/2020 To 06/30/2021		Worksheet E Part A Exhibit 5 Date/Time Prepared: 11/29/2021 3:10 pm	
			Title XVIII		Hospital		PPS	
			Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
			0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00						1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01		741,397	741,397		741,397	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02		3,133,627		3,133,627	3,133,627	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		13,671	13,671		13,671	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04		219,522		219,522	219,522	2.03
3.00	Operating outlier reconciliation	2.01		0	0	0	0	3.00
4.00	Managed care simulated payments	3.00		51,037	0	51,037	51,037	4.00
Indirect Medical Education Adjustment								
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00		0.035759	0.035759	0.035759		5.00
6.00	IME payment adjustment (see instructions)	22.00		74,970	14,344	60,626	74,970	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01		987	0	987	987	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		74,970	14,344	60,626	74,970	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01		987	0	987	987	9.01
Disproportionate Share Adjustment								
10.00	Allowable disproportionate share percentage (see instructions)	33.00		0.1200	0.1200	0.1200		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00		116,251	22,242	94,009	116,251	11.00
11.01	Uncompensated care payments	36.00		1,689,368	461,804	1,227,564	1,689,368	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		5,988,806	1,253,458	4,735,348	5,988,806	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		5,989,793	1,253,458	4,736,335	5,989,793	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00		298,644	59,623	239,021	298,644	16.00
17.00	Special add-on payments for new technologies	54.00		78,936	0	78,936	78,936	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				1,313,081	5,054,292	6,367,373	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5			Provider CCN: 14-0095		Period: From 07/01/2020 To 06/30/2021		Worksheet E Part A Exhibit 5 Date/Time Prepared: 11/29/2021 3:10 pm	
			Title XVIII		Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)					
		0	1.00	2.00	3.00	4.00		
20.00	Capital DRG other than outlier	1.00	289,619	58,231	231,388	289,619	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	2,103	0	2,103	2,103	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	0.0239	0.0239	0.0239		22.00	
23.00	Indirect medical education adjustment (see instructions)	6.00	6,922	1,392	5,530	6,922	23.00	
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00	
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00	
26.00	Total prospective capital payments (see instructions)	12.00	298,644	59,623	239,021	298,644	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	33,670	6,723	26,947	33,670	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	-8,056	-4,522	-3,534	-8,056	31.00	
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01	
						(Amt. to Wkst. E, Pt. A)		
		0	1.00	2.00	3.00	4.00		
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00	
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN:14-0095	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part B Date/Time Prepared: 11/29/2021 3:10 pm
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		9,167	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		2,948,136	2.00
3.00	OPPS payments		1,847,752	3.00
4.00	Outlier payment (see instructions)		41,010	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)		9,167	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		37,559	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)		37,559	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)		37,559	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		28,392	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)		9,167	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)		1,888,762	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)		407,531	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)		1,490,398	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		23,056	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)		1,513,454	30.00
31.00	Primary payer payments		431	31.00
32.00	Subtotal (line 30 minus line 31)		1,513,023	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)		377,064	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		245,092	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		204,848	36.00
37.00	Subtotal (see instructions)		1,758,115	37.00
38.00	MSP-LCC reconciliation amount from PS&R		862	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		1,757,253	40.00
40.01	Sequestration adjustment (see instructions)		0	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		0	40.03
41.00	Interim payments		1,661,171	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)		96,082	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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0095 Component CCN: 14-S095	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part B Date/Time Prepared: 11/29/2021 3:10 pm
		Title XVIII	Subprovider - IPF	PPS
			1.00	
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		231	2.00
3.00	OPPS payments		139	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		0	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		0	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		139	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)		28	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)		111	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)		111	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		111	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)		111	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)		111	40.00
40.01	Sequestration adjustment (see instructions)		0	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03	
41.00	Interim payments		111	41.00
41.01	Interim payments-PARHM		41.01	
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		42.01	
43.00	Balance due provider/program (see instructions)		0	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01	
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0095

Period:
From 07/01/2020
To 06/30/2021Worksheet E-1
Part I
Date/Time Prepared:
11/29/2021 3:10 pm

		Title XVIII		Hospital		PPS
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		5,948,817		1,698,206	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	03/06/2021	45,203	03/06/2021	37,035	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)		-45,203		-37,035	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)		5,903,614		1,661,171	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		373,018		96,082	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		6,276,632		1,757,253	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: 14-0095 Component CCN: 14-S095		Period: From 07/01/2020 To 06/30/2021		Worksheet E-1 Part I Date/Time Prepared: 11/29/2021 3:10 pm	
		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		1,186,295		111		2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.00
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0		3.01
3.02			0		0		3.02
3.03			0		0		3.03
3.04			0		0		3.04
3.05			0		0		3.05
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0		3.50
3.51			0		0		3.51
3.52			0		0		3.52
3.53			0		0		3.53
3.54			0		0		3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0		3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,186,295		111		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		39,326		0		6.01
6.02	SETTLEMENT TO PROGRAM		0		0		6.02
7.00	Total Medicare program liability (see instructions)		1,225,621		111		7.00
		0		Contractor Number	NPR Date (Mo/Day/Yr)		
				1.00	2.00		
8.00	Name of Contractor					8.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 14-0095	Period: From 07/01/2020 To 06/30/2021	Worksheet E-1 Part II Date/Time Prepared: 11/29/2021 3:10 pm
		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN:14-0095	Period: From 07/01/2020 To 06/30/2021	Worksheet E-3 Part II Date/Time Prepared: 11/29/2021 3:10 pm
		Component CCN:14-S095		
		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)		1,430,672	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)		30.419178	9.00
10.00	Teaching Adjustment Factor $\{((1 + (\text{line 8}/\text{line 9})) \text{ raised to the power of } .5150 - 1)\}$.		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)		1,430,672	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)		1,430,672	16.00
17.00	Primary payer payments		0	17.00
18.00	Subtotal (line 16 less line 17).		1,430,672	18.00
19.00	Deductibles		106,200	19.00
20.00	Subtotal (line 18 minus line 19)		1,324,472	20.00
21.00	Coinsurance		138,177	21.00
22.00	Subtotal (line 20 minus line 21)		1,186,295	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		60,502	23.00
24.00	Adjusted reimbursable bad debts (see instructions)		39,326	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		19,707	25.00
26.00	Subtotal (sum of lines 22 and 24)		1,225,621	26.00
27.00	Direct graduate medical education payments (see instructions)		0	27.00
28.00	Other pass through costs (see instructions)		0	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)		1,225,621	31.00
31.01	Sequestration adjustment (see instructions)		0	31.01
31.02	Demonstration payment adjustment amount after sequestration		0	31.02
32.00	Interim payments		1,186,295	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)		39,326	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: 14-0095	Period: From 07/01/2020 To 06/30/2021	Worksheet E-3 Part VII Date/Time Prepared: 11/29/2021 3:10 pm	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		5,836,833		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)		5,836,833	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)		5,836,833	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		5,269,453		8.00
9.00	Ancillary service charges		10,305,095	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)		15,574,548	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)		15,574,548	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		9,737,715	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	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)		5,836,833	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		28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		5,836,833	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		5,836,833	0	31.00
32.00	Deductibles		0		32.00
33.00	Coinurance		0		33.00
34.00	Allowable bad debts (see instructions)		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)		5,836,833	0	36.00
37.00	INTERIM PAYMENT RECONCILIATION		-3,108,159	0	37.00
38.00	Subtotal (line 36 ± line 37)		2,728,674	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)		2,728,674	0	40.00
41.00	Interim payments		2,728,674	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		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: 14-0095 Component CCN: 14-S095	Period: From 07/01/2020 To 06/30/2021	Worksheet E-3 Part VII Date/Time Prepared: 11/29/2021 3:10 pm
		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	0		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)	0	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)	0	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)	0	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)	0	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	Coinsurance	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: 14-0095		Period: From 07/01/2020 To 06/30/2021	Worksheet E-4 Date/Time Prepared: 11/29/2021 3:10 pm	
		Title XVIII		Hospital		PPS
						1.00
COMPUTATION OF TOTAL DIRECT GME AMOUNT						
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.					5.59 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					2.33 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)					1.17 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)					2.09 5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)					4.14 6.00
7.00	Enter the lesser of line 5 or line 6					2.09 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.	4.14	0.00	4.14		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.	2.09	0.00	2.09		9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		1.64			10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		1.64			10.01
11.00	Total weighted FTE count	2.09	1.64			11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	2.09	1.63			12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	2.09	1.56			13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	2.09	1.61			14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00			15.00
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00			15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00			16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00			16.01
17.00	Adjusted rolling average FTE count	2.09	1.61			17.00
18.00	Per resident amount	156,974.09	147,768.79			18.00
19.00	Approved amount for resident costs	328,076	237,908	565,984		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)			2.05		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)			565,984		25.00
		Inpatient Part A	Managed Care Prior to 1/1	Managed Care On or after 1/1	Total	
		1.00	2.00	2.01	3.00	
COMPUTATION OF PROGRAM PATIENT LOAD						
26.00	Inpatient Days (see instructions) (Title XIX - see S-2 Part IX, line 3.02, column 2)	3,947	0	31	26.00	
27.00	Total Inpatient Days (see instructions)	27,284	27,284	27,284	27.00	
28.00	Ratio of inpatient days to total inpatient days	0.144664	0.000000	0.001136	28.00	
29.00	Program direct GME amount	81,878	0	643	82,521	29.00
29.01	Percent reduction for MA DGME		4.07	4.07		29.01
30.00	Reduction for direct GME payments for Medicare Advantage		0	26	26	30.00
31.00	Net Program direct GME amount				82,495	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN:14-0095	Period: From 07/01/2020 To 06/30/2021	Worksheet E-4 Date/Time Prepared: 11/29/2021 3:10 pm	
		Title XVIII	Hospital	PPS	
				1.00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)			0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)			0	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)			0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)			0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)			0	36.00
APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY					
Part A Reasonable Cost					
37.00	Reasonable cost (see instructions)			7,632,549	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)			9,261	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)			7,623,288	41.00
Part B Reasonable Cost					
42.00	Reasonable cost (see instructions)			2,957,534	42.00
43.00	Primary payer payments (see instructions)			431	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)			2,957,103	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)			10,580,391	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)			0.720511	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)			0.279489	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B					
48.00	Total program GME payment (line 31)			82,495	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)			59,439	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)			23,056	50.00

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

Provider CCN: 14-0095

Period:
From 07/01/2020
To 06/30/2021

Worksheet G

Date/Time Prepared:
11/29/2021 3:10 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	23,199,640	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	111,188,873	0	0	0	4.00
5.00	Other receivable	2,482,579	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-94,606,815	0	0	0	6.00
7.00	Inventory	1,833,569	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	1,210,395	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	45,308,241	0	0	0	11.00
FIXED ASSETS						
12.00	Land	472,850	0	0	0	12.00
13.00	Land improvements	550,741	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	27,309,289	0	0	0	15.00
16.00	Accumulated depreciation	-16,269,000	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	49,805,769	0	0	0	23.00
24.00	Accumulated depreciation	-47,147,615	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)	14,722,034	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	33,227,689	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	8,363,617	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	41,591,306	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	101,621,581	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	9,560,977	0	0	0	37.00
38.00	Salaries, wages, and fees payable	4,553,719	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	3,067,262	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	62,901,282	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	80,083,240	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	10,854,257	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	10,854,257	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	90,937,497	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	10,684,084				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	10,684,084	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	101,621,581	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0095

Period:
From 07/01/2020
To 06/30/2021

Worksheet G-1

Date/Time Prepared:
11/29/2021 3:10 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		23,324,076		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-12,639,992				2.00
3.00	Total (sum of line 1 and line 2)		10,684,084		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		10,684,084		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		10,684,084		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			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-0095

Period:
From 07/01/2020
To 06/30/2021Worksheet G-2
Parts I & II
Date/Time Prepared:
11/29/2021 3:10 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	23,065,691		23,065,691	1.00
2.00	SUBPROVIDER - IPF	18,136,798		18,136,798	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)	41,202,489		41,202,489	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	13,820,071		13,820,071	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	13,820,071		13,820,071	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	55,022,560		55,022,560	17.00
18.00	Ancillary services	98,280,464		98,280,464	18.00
19.00	Outpatient services	0	173,202,637	173,202,637	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
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	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	153,303,024	173,202,637	326,505,661	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		125,434,496		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT : PROVIDER ASSESSMENT TAX	7,229,612			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		7,229,612		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		118,204,884		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0095

Period:
From 07/01/2020
To 06/30/2021

Worksheet G-3

Date/Time Prepared:
11/29/2021 3:10 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	326,505,661	1.00
2.00	Less contractual allowances and discounts on patients' accounts	231,479,829	2.00
3.00	Net patient revenues (line 1 minus line 2)	95,025,832	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	118,204,884	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-23,179,052	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	18,223	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	571,793	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	265	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	349,340	22.00
23.00	Governmental appropriations	0	23.00
24.00	MED STUDENT PROG - OTH OPER REV	1,827,715	24.00
24.01	VOCA GRANT - OTH OPER REV	457,869	24.01
24.02	COMPASS - OTH OPER REV	96,357	24.02
24.03	FINANCE DEPT - INTEREST INCOME	122,885	24.03
24.04	CARDIOLOGY - OTH OPER REV	167,940	24.04
24.05	PHARMACY - OTH OPER REV	164,886	24.05
24.06	FINANCIAL CNTR - OTH OPER REV	401,251	24.06
24.07	FINANCE DEPT - OTH OPER REV	161,416	24.07
24.08	ADMINISTRATION - OTH OPER REV	596,532	24.08
24.09	OTHER MISC REV	190,473	24.09
24.50	COVID-19 PHE Funding	5,412,115	24.50
25.00	Total other income (sum of lines 6-24)	10,539,060	25.00
26.00	Total (line 5 plus line 25)	-12,639,992	26.00
27.00	OTHER EXPENSES (SPECIFY)	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)	-12,639,992	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0095	Period: From 07/01/2020 To 06/30/2021	Worksheet L Parts I-III Date/Time Prepared: 11/29/2021 3:10 pm
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		289,619	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		2,103	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)		44.33	3.00
4.00	Number of interns & residents (see instructions)		3.70	4.00
5.00	Indirect medical education percentage (see instructions)		2.39	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)		6,922	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		0.00	8.00
9.00	Sum of lines 7 and 8		0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)		0.00	10.00
11.00	Disproportionate share adjustment (see instructions)		0	11.00
12.00	Total prospective capital payments (see instructions)		298,644	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