

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY		Provider CCN: 14-0213	Period: From 10/01/2020 To 09/30/2021	Worksheet S Parts I-III Date/Time Prepared: 2/28/2022 12:24 pm
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PART I - COST REPORT STATUS

Provider use only

1. ☒ Electronically prepared cost report
2. ☐ Manually prepared cost report
3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report
4. ☒ Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. ☒ Cost Report Status
(1) As Submitted
(2) Settled without Audit
(3) Settled with Audit
(4) Reopened
(5) Amended

6. Date Received:
7. Contractor No.
8. ☒ Initial Report for this Provider CCN
9. ☒ Final Report for this Provider CCN

10. NPR Date:
11. Contractor's Vendor Code: 4
12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

Date: 2/28/2022 Time: 12:24 pm

PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S)

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by SILVER CROSS HOSPITAL (14-0213) for the cost reporting period beginning 10/01/2020 and ending 09/30/2021 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.

SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR		CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
1		2		
1	Vincent Pryor	Y	I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name Vincent Pryor			2
3	Signatory Title EXEC V.P & CFO			3
4	Date 02/28/2022 01:05:20 PM (PT)			4

Encryption Information
ECR: Date: 2/28/2022 Time: 12:24 pm
Bp3finIVlkSuK1gni85liMCi8Fxjz0
KkLtf0sto7oGtaI0uR0LDy4alE01F.
xDMP1NHV:G04IB0G

		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	200,098	-31,963	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	13,927	0		0	3.00
4.00	SUBPROVIDER I						4.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
8.00	NURSING FACILITY	0				0	8.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
12.00	CMHC I	0		0		0	12.00
200.00	Total	0	214,025	-31,963	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: 14-0213		Period: From 10/01/2020 To 09/30/2021		Worksheet S-2 Part I Date/Time Prepared: 2/28/2022 12:24 pm		
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 1900 SILVER CROSS BLVD.			PO Box:				1.00		
2.00	City: NEW LENOX			State: IL		Zip Code: 60451		County: WILL 2.00		
		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
							V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
Hospital and Hospital-Based Component Identification:										
3.00	Hospital		SILVER CROSS HOSPITAL	140213	16984	1	07/01/1966	N	P	P
4.00	Subprovider - IPF									
5.00	Subprovider - IRF		SCH - REHAB	14T213	16974	5	10/01/2000	N	P	P
6.00	Subprovider - (Other)									
7.00	Swing Beds - SNF									
8.00	Swing Beds - NF									
9.00	Hospital-Based SNF									
10.00	Hospital-Based NF									
11.00	Hospital-Based OLTC									
12.00	Hospital-Based HHA		SCH HOME HEALTH	147452	16974		04/01/1994	N	P	N
13.00	Separately Certified ASC									
14.00	Hospital-Based Hospice									
15.00	Hospital-Based Health Clinic - RHC									
16.00	Hospital-Based Health Clinic - FQHC									
17.00	Hospital-Based (CMHC) I									
17.10	Hospital-Based (CORF) I									
18.00	Renal Dialysis									
19.00	Other									
						From:	To:			
						1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)					10/01/2020	09/30/2021		20.00	
21.00	Type of Control (see instructions)					1			21.00	
						1.00	2.00	3.00		
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.				Y	N			22.00	
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)				N	Y			22.01	
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.				N	N			22.02	
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.				N	N	N		22.03	
22.04	Did this hospital receive a geographic reclassification from urban to rural as a result of the revised OMB delineations for statistical areas adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.				N	N	N		22.04	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.				1	N			23.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0213

Period:
From 10/01/2020
To 09/30/2021Worksheet S-2
Part I
Date/Time Prepared:
2/28/2022 12:24 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.	2,330	1,905	0	0	7,881	710	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.	31	97	0	0	123		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)					Y	Y	N
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
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
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N
	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.					N		
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.							
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		
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0213		Period: From 10/01/2020 To 09/30/2021		Worksheet S-2 Part I Date/Time Prepared: 2/28/2022 12:24 pm	
		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code			
		1.00	2.00	3.00			
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.	Y	Y			60.00	
60.01	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		23.00	1		60.01	
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
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	
<u>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</u>							
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
<u>Teaching Hospitals that Claim Residents in Nonprovider Settings</u>							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0213

Period:
From 10/01/2020
To 09/30/2021Worksheet S-2
Part I
Date/Time Prepared:
2/28/2022 12:24 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.	N			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N	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.	Y			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N	N	0	76.00
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N		80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N		81.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N		87.00
			V	XIX	
			1.00	2.00	
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y		90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N		91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N		92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N		94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N		96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N		98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N		98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y		98.06
Rural Providers					
105.00	Does this hospital qualify as a CAH?	N			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N			106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N			107.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0213		Period: From 10/01/2020 To 09/30/2021		Worksheet S-2 Part I Date/Time Prepared: 2/28/2022 12:24 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.	N	N	N	N	109.00	
				1.00			
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N				110.00	
				1.00	2.00		
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N				111.00	
		1.00	2.00	3.00			
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N				112.00	
Miscellaneous Cost Reporting Information							
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N				0115.00	
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00	
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N				117.00	
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1				118.00	
		Premiums	Losses	Insurance			
		1.00	2.00	3.00			
118.01	List amounts of malpractice premiums and paid losses:	0	0	0	0	118.01	
				1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N				118.02	
119.00	DO NOT USE THIS LINE					119.00	
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N		120.00	
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y				121.00	
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N				122.00	
Transplant Center Information							
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N				125.00	
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126.00	
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					127.00	
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00	
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00	
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0213		Period: From 10/01/2020 To 09/30/2021		Worksheet S-2 Part I Date/Time Prepared: 2/28/2022 12:24 pm	
		1.00		2.00			
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00	
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00	
133.00	Removed and reserved					133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00	
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		HB2292		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: SILVER CROSS HOSPITAL HOME OFFICE	Contractor's Name: NGS		Contractor's Number: 06101		141.00	
142.00	Street: 1900 SILVER CROSS BLVD.	PO Box:				142.00	
143.00	City: NEW LENOX	State: IL		Zip Code: 60451		143.00	
				1.00			
144.00	Are provider based physicians' costs included in Worksheet A?			Y		144.00	
		1.00		2.00			
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	Y				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	
161.10	CORF			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	
						FTE/Campus	
						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: 14-0213	Period: From 10/01/2020 To 09/30/2021	Worksheet S-2 Part I Date/Time Prepared: 2/28/2022 12:24 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: 14-0213	Period: From 10/01/2020 To 09/30/2021	Worksheet S-2 Part II Date/Time Prepared: 2/28/2022 12:24 pm
			Y/N 1.00	Date 2.00
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y		3.00
		Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
			Y/N 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	Y		7.00
8.00	Were nursing programs and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N 1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N		13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N		14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	Y		15.00
		Part A		Part B
		Y/N 1.00	Date 2.00	Y/N 3.00
				Date 4.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	12/07/2021	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		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		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0213

Period:
From 10/01/2020
To 09/30/2021Worksheet S-2
Part II
Date/Time Prepared:
2/28/2022 12:24 pm

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	KAY	NOVAK		41.00
42.00	Enter the employer/company name of the cost report preparer.	SILVER CROSS HOSPITAL			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	815-300-7029	KNOVAK@SILVERCROSS.ORG		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0213

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0213

Period:
From 10/01/2020
To 09/30/2021Worksheet S-3
Part I
Date/Time Prepared:
2/28/2022 12:24 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	242	88,330	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)		242	88,330	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	30	10,950	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT	33.00	0	0	0.00	0	10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		272	99,280	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	0	0		0	16.00
17.00 SUBPROVIDER - IRF	41.00	28	10,220		0	17.00
18.00 SUBPROVIDER	42.00	0	0		0	18.00
19.00 SKILLED NURSING FACILITY	44.00	0	0		0	19.00
20.00 NURSING FACILITY	45.00	0	0		0	20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC	99.00				0	25.00
25.10 CMHC - CORF	99.10				0	25.10
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		300				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0213

Period:
From 10/01/2020
To 09/30/2021Worksheet S-3
Part I
Date/Time Prepared:
2/28/2022 12:24 pm

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	26,947	3,400	68,474			1.00
2.00	HMO and other (see instructions)	12,065	7,881				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	855	123				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	26,947	3,400	68,474			7.00
8.00	INTENSIVE CARE UNIT	4,640	457	9,205			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT	0	0	0			10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		378	7,612			13.00
14.00	Total (see instructions)	31,587	4,235	85,291	0.00	1,915.42	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	0	0	0	0.00	0.00	16.00
17.00	SUBPROVIDER - IRF	5,473	128	8,492	0.00	54.22	17.00
18.00	SUBPROVIDER		0	0	0.00	0.00	18.00
19.00	SKILLED NURSING FACILITY	0	0	0	0.00	0.00	19.00
20.00	NURSING FACILITY		0	0	0.00	0.00	20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	13,318	0	26,666	0.00	35.11	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC	0	0	0	0.00	0.00	25.00
25.10	CMHC - CORF	0	0	0	0.00	0.00	25.10
26.00	RURAL HEALTH CLINIC	0	0	0	0.00	0.00	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	2,004.75	27.00
28.00	Observation Bed Days		1,683	11,559			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	710	2,160			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0213

Period:
From 10/01/2020
To 09/30/2021Worksheet S-3
Part I
Date/Time Prepared:
2/28/2022 12:24 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	6,754	1,540	19,267	1.00
2.00 HMO and other (see instructions)			2,279	2,263		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				8		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	6,754	1,540	19,267	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	0	0	0	16.00
17.00 SUBPROVIDER - IRF	0.00	0	446	15	750	17.00
18.00 SUBPROVIDER	0.00	0		0	0	18.00
19.00 SKILLED NURSING FACILITY	0.00					19.00
20.00 NURSING FACILITY	0.00					20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0.00					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC	0.00					25.00
25.10 CMHC - CORF	0.00					25.10
26.00 RURAL HEALTH CLINIC	0.00					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0213

Period:
From 10/01/2020
To 09/30/2021Worksheet S-3
Part II
Date/Time Prepared:
2/28/2022 12:24 pm

	Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	150,491,380	0	150,491,380	4,169,882.64	36.09
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		7,943,459	0	7,943,459	196,980.80	40.33
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		6,997,163	0	6,997,163	70,025.48	99.92
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract labor: Physician-Part A - Administrative		898,619	0	898,619	6,930.50	129.66
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		7,567,164	0	7,567,164	18,768.00	403.20
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		37,820,257	0	37,820,257		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		2,107,211	0	2,107,211		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		0	0	0		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0213

Period:
From 10/01/2020
To 09/30/2021Worksheet S-3
Part II
Date/Time Prepared:
2/28/2022 12:24 pm

		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	1,337,281	0	1,337,281	32,307.20	41.39	26.00
27.00	Administrative & General	5.00	22,323,110	-53,707	22,269,403	637,468.40	34.93	27.00
28.00	Administrative & General under contract (see inst.)		868,435	0	868,435	28,118.60	30.88	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	3,683,240	0	3,683,240	136,718.40	26.94	30.00
31.00	Laundry & Linen Service	8.00	73,807	0	73,807	4,268.80	17.29	31.00
32.00	Housekeeping	9.00	2,811,054	0	2,811,054	156,948.80	17.91	32.00
33.00	Housekeeping under contract (see instructions)		637,896	0	637,896	23,368.25	27.30	33.00
34.00	Dietary	10.00	2,377,212	-1,652,231	724,981	42,141.66	17.20	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	1,652,231	1,652,231	96,040.74	17.20	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	3,390,572	0	3,390,572	82,961.60	40.87	38.00
39.00	Central Services and Supply	14.00	1,668,807	-925,855	742,952	37,221.60	19.96	39.00
40.00	Pharmacy	15.00	4,353,215	0	4,353,215	90,491.20	48.11	40.00
41.00	Medical Records & Medical Records Library	16.00	2,926,276	0	2,926,276	92,025.60	31.80	41.00
42.00	Social Service	17.00	0	53,707	53,707	2,146.00	25.03	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0213

Period:
From 10/01/2020
To 09/30/2021Worksheet S-3
Part III
Date/Time Prepared:
2/28/2022 12:24 pm

	Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	151,997,711	0	151,997,711	4,221,369.49	36.01	1.00
2.00	Excluded area salaries (see instructions)	7,943,459	0	7,943,459	196,980.80	40.33	2.00
3.00	Subtotal salaries (line 1 minus line 2)	144,054,252	0	144,054,252	4,024,388.69	35.80	3.00
4.00	Subtotal other wages & related costs (see inst.)	15,462,946	0	15,462,946	95,723.98	161.54	4.00
5.00	Subtotal wage-related costs (see inst.)	37,820,257	0	37,820,257	0.00	26.25	5.00
6.00	Total (sum of lines 3 thru 5)	197,337,455	0	197,337,455	4,120,112.67	47.90	6.00
7.00	Total overhead cost (see instructions)	46,450,905	-925,855	45,525,050	1,462,226.85	31.13	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 14-0213	Period: From 10/01/2020 To 09/30/2021	Worksheet S-3 Part IV Date/Time Prepared: 2/28/2022 12:24 pm
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions			0 1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution			0 2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)		9,865,344	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)		11,592,519	8.02
8.03	Health Insurance (Purchased)		4,940,265	8.03
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		580,136	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		147,263	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)		663,072	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		1,836,313	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		11,150,771	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		-1,019,547	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		171,332	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		39,927,468	24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)			25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 14-0213

Period:
From 10/01/2020
To 09/30/2021Worksheet S-3
Part V
Date/Time Prepared:
2/28/2022 12:24 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	6,997,163	39,927,468	1.00
2.00	Hospital	6,997,163	39,927,468	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	0	0	8.00
9.00	Hospital-Based NF	0	0	9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
15.00	Hospital-Based Health Clinic FQHC	0	0	15.00
16.00	Hospital-Based-CMHC	0	0	16.00
16.10	Hospital-Based-CMHC 10	0	0	16.10
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

Health Financial Systems		SILVER CROSS HOSPITAL			In Lieu of Form CMS-2552-10		
HOME HEALTH AGENCY STATISTICAL DATA				Provider CCN: 14-0213 Component CCN: 14-7452		Period: From 10/01/2020 To 09/30/2021	
				Home Health Agency I		Worksheet S-4 Date/Time Prepared: 2/28/2022 12:24 pm	
						PPS	
						1.00	
0.00 County						0.00	
				Title V	Title XVIII	Title XIX	Other
				1.00	2.00	3.00	4.00
						Total	5.00
HOME HEALTH AGENCY STATISTICAL DATA							
1.00	Home Health Aide Hours	0	2,826	2	757	3,585	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	720.00	37.00	747.00	0.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES							
3.00	Administrator and Assistant Administrator(s)	0.00		6.53	0.00	6.53	3.00
4.00	Director(s) and Assistant Director(s)			1.42	0.00	1.42	4.00
5.00	Other Administrative Personnel			5.33	0.00	5.33	5.00
6.00	Direct Nursing Service			12.05	0.31	12.36	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			4.92	0.40	5.32	8.00
9.00	Physical Therapy Supervisor			0.93	0.00	0.93	9.00
10.00	Occupational Therapy Service			3.60	0.00	3.60	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.00	0.00	0.00	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.34	0.00	0.34	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			0.00	0.00	0.00	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	Other (specify)			0.00	0.00	0.00	18.00
						CBSA Data	
						1.00	
HOME HEALTH AGENCY CBSA CODES							
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.					2	19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).					16974	20.00
20.01						16984	20.01
		Full Episodes		LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		Without Outliers	With Outliers				
		1.00	2.00	3.00	4.00	5.00	
PPS ACTIVITY DATA							
21.00	Skilled Nursing Visits	5,993	469	153	38	6,653	21.00
22.00	Skilled Nursing Visit Charges	1,443,114	112,935	36,842	9,150	1,602,041	22.00
23.00	Physical Therapy Visits	3,362	463	33	16	3,874	23.00
24.00	Physical Therapy Visit Charges	754,172	104,545	6,097	3,613	868,427	24.00
25.00	Occupational Therapy Visits	1,555	409	14	13	1,991	25.00
26.00	Occupational Therapy Visit Charges	345,474	92,352	3,161	2,935	443,922	26.00
27.00	Speech Pathology Visits	54	27	0	0	81	27.00
28.00	Speech Pathology Visit Charges	12,941	6,471	0	0	19,412	28.00
29.00	Medical Social Service Visits	34	8	0	1	43	29.00
30.00	Medical Social Service Visit Charges	11,212	2,638	0	330	14,180	30.00
31.00	Home Health Aide Visits	722	222	0	3	947	31.00
32.00	Home Health Aide Visit Charges	103,222	32,690	0	442	136,354	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	11,720	1,598	200	71	13,589	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	2,670,135	351,631	46,100	16,470	3,084,336	35.00
36.00	Total Number of Episodes (standard/non outlier)	1,234		122	9	1,365	36.00
37.00	Total Number of Outlier Episodes		67		0	67	37.00
38.00	Total Non-Routine Medical Supply Charges	0	0	0	0	0	38.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 14-0213

Period:
From 10/01/2020
To 09/30/2021

Worksheet S-10

Date/Time Prepared:
2/28/2022 12:24 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)		0.277640	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		30,430,919	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		149,497,027	6.00
7.00	Medicaid cost (line 1 times line 6)		41,506,355	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)		11,075,436	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)		11,075,436	19.00
			Uninsured patients	Insured patients
			1.00	2.00
			Total (col. 1 + col. 2)	3.00
Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	8,439,872	4,142,063	12,581,935
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	2,343,246	4,142,063	6,485,309
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0
23.00	Cost of charity care (line 21 minus line 22)	2,343,246	4,142,063	6,485,309
			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)		11,829,831	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		835,627	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		1,285,580	27.01
28.00	Non-Medicare bad debt expense (see instructions)		10,544,251	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		3,377,459	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		9,862,768	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		20,938,204	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0213

Period:
From 10/01/2020
To 09/30/2021

Worksheet A

Date/Time Prepared:
2/28/2022 12:24 pm

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		55,774,377	55,774,377	-27,581,174	28,193,203	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	17,447,410	17,447,410	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,337,281	40,776,615	42,113,896	-23,332	42,090,564	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	22,323,110	64,005,100	86,328,210	3,421,836	89,750,046	5.00
7.00	00700	OPERATION OF PLANT	3,683,240	7,819,229	11,502,469	-51,099	11,451,370	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	73,807	96,305	170,112	0	170,112	8.00
9.00	00900	HOUSEKEEPING	2,811,054	2,400,676	5,211,730	-15,642	5,196,088	9.00
10.00	01000	DIETARY	2,377,212	2,509,860	4,887,072	-3,441,025	1,446,047	10.00
11.00	01100	CAFETERIA	0	0	0	3,396,656	3,396,656	11.00
13.00	01300	NURSING ADMINISTRATION	3,390,572	128,186	3,518,758	-30,152	3,488,606	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,668,807	2,592,670	4,261,477	-3,513,044	748,433	14.00
15.00	01500	PHARMACY	4,353,215	23,010,174	27,363,389	-19,909,649	7,453,740	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,926,276	493,714	3,419,990	-2,050	3,417,940	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	53,707	53,707	17.00
23.00	02300	PARAMED ED PRGM	410,255	370,630	780,885	-156,787	624,098	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	31,115,209	6,821,185	37,936,394	954,284	38,890,678	30.00
31.00	03100	INTENSIVE CARE UNIT	7,381,785	3,123,636	10,505,421	-942,194	9,563,227	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	4,316,054	792,157	5,108,211	-89,651	5,018,560	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	10,860,204	1,017,466	11,877,670	-6,808,620	5,069,050	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	10,663,893	37,263,638	47,927,531	-26,157,197	21,770,334	50.00
51.00	05100	RECOVERY ROOM	1,531,112	103,040	1,634,152	-45,380	1,588,772	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,125,163	1,125,163	2,547,985	3,673,148	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,329,350	17,576,834	26,906,184	-12,496,254	14,409,930	54.00
54.01	05401	ULTRASOUND	1,314,283	420,615	1,734,898	-199,754	1,535,144	54.01
57.00	05700	CT SCAN	1,321,825	1,239,540	2,561,365	-382,266	2,179,099	57.00
58.00	05800	MRI	764,389	507,709	1,272,098	-64,408	1,207,690	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	4,647,224	14,372,685	19,019,909	-8,593,767	10,426,142	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING PROCESSING & TRANS.	269,982	2,012,610	2,282,592	-228,529	2,054,063	63.00
65.00	06500	RESPIRATORY THERAPY	2,171,134	1,019,705	3,190,839	-265,461	2,925,378	65.00
65.01	06501	SLEEP LAB	250,905	171,403	422,308	79,736	502,044	65.01
66.00	06600	PHYSICAL THERAPY	1,639,423	331,374	1,970,797	-5,680	1,965,117	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,889,861	437,113	2,326,974	-38,923	2,288,051	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,727,773	297,597	2,025,370	2,189,626	4,214,996	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	155,794	28,850	184,644	1,515,386	1,700,030	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	39,335,013	39,335,013	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	22,339,160	22,339,160	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	19,754,275	19,754,275	73.00
74.00	07400	RENAL DIALYSIS	470,969	205,813	676,782	-50,157	626,625	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	631,365	1,078,536	1,709,901	-705,898	1,004,003	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	0	90.02
90.03	09003	WOMENS HEALTH	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	9,109,724	3,719,138	12,828,862	-1,174,073	11,654,789	91.00
91.01	09101	OP MENTAL HEALTH	0	0	0	0	0	91.01
91.02	09102	DIABETES CENTER	357,143	5,120	362,263	-65,776	296,487	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	3,193,381	440,818	3,634,199	2,868	3,637,067	101.00
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	150,467,611	294,089,281	444,556,892	0	444,556,892	118.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0213

Period:
From 10/01/2020
To 09/30/2021

Worksheet A

Date/Time Prepared:
2/28/2022 12:24 pm

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	22,640	0	22,640	0	22,640	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	FOUNDATION	1,129	0	1,129	0	1,129	192.01
200.00		TOTAL (SUM OF LINES 118 through 199)	150,491,380	294,089,281	444,580,661	0	444,580,661	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0213

Period:
From 10/01/2020
To 09/30/2021

Worksheet A

Date/Time Prepared:
2/28/2022 12:24 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	-15,667,454	12,525,749	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	17,447,410	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-88,420	42,002,144	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-21,066,986	68,683,060	5.00
7.00	00700	OPERATION OF PLANT	-160	11,451,210	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	170,112	8.00
9.00	00900	HOUSEKEEPING	-1	5,196,087	9.00
10.00	01000	DIETARY	-2,829	1,443,218	10.00
11.00	01100	CAFETERIA	-1,657,789	1,738,867	11.00
13.00	01300	NURSING ADMINISTRATION	0	3,488,606	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-19,986	728,447	14.00
15.00	01500	PHARMACY	0	7,453,740	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-3,638	3,414,302	16.00
17.00	01700	SOCIAL SERVICE	0	53,707	17.00
23.00	02300	PARAMED ED PRGM	-198,974	425,124	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-1,884,114	37,006,564	30.00
31.00	03100	INTENSIVE CARE UNIT	-621,910	8,941,317	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	33.00
40.00	04000	SUBPROVIDER - IPF	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	-108,853	4,909,707	41.00
42.00	04200	SUBPROVIDER	0	0	42.00
43.00	04300	NURSERY	-1,645	5,067,405	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	45.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-542,638	21,227,696	50.00
51.00	05100	RECOVERY ROOM	0	1,588,772	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	3,673,148	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-89,865	14,320,065	54.00
54.01	05401	ULTRASOUND	0	1,535,144	54.01
57.00	05700	CT SCAN	0	2,179,099	57.00
58.00	05800	MRI	0	1,207,690	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	-61,940	10,364,202	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0	2,054,063	63.00
65.00	06500	RESPIRATORY THERAPY	-73,235	2,852,143	65.00
65.01	06501	SLEEP LAB	-110,000	392,044	65.01
66.00	06600	PHYSICAL THERAPY	0	1,965,117	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,288,051	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	-2,197,560	2,017,436	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	-1,461,700	238,330	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	39,335,013	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	22,339,160	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	19,754,275	73.00
74.00	07400	RENAL DIALYSIS	-17,641	608,984	74.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	52,212	1,056,215	90.00
90.01	09001	HOMER GLEN LAB	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	90.02
90.03	09003	WOMENS HEALTH	0	0	90.03
91.00	09100	EMERGENCY	-514,526	11,140,263	91.00
91.01	09101	OP MENTAL HEALTH	0	0	91.01
91.02	09102	DIABETES CENTER	0	296,487	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
94.00	09400	HOME PROGRAM DIALYSIS	0	0	94.00
99.00	09900	CMHC	0	0	99.00
99.10	09910	CORF	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	3,637,067	101.00
SPECIAL PURPOSE COST CENTERS					
109.00	10900	PANCREAS ACQUISITION	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-46,339,652	398,217,240	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	22,640	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	192.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0213

Period:
From 10/01/2020
To 09/30/2021

Worksheet A

Date/Time Prepared:
2/28/2022 12:24 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
192.01	19201	FOUNDATION	0	1,129	192.01
200.00		TOTAL (SUM OF LINES 118 through 199)	-46,339,652	398,241,009	200.00

RECLASSIFICATIONS

Provider CCN: 14-0213

Period:
From 10/01/2020
To 09/30/2021

Worksheet A-6

Date/Time Prepared:
2/28/2022 12:24 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - STERILE PROCESSING					
1.00	ADULTS & PEDIATRICS	30.00	12,962	27,440		1.00
2.00	OPERATING ROOM	50.00	829,566	1,756,157		2.00
3.00	DELIVERY ROOM & LABOR ROOM	52.00	58,329	123,480		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	6,481	13,720		4.00
5.00	CLINIC	90.00	3,703	7,840		5.00
6.00	EMERGENCY	91.00	14,814	31,360		6.00
	0		925,855	1,959,997		
	C - CAPITAL INSURANCE					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	256,134		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	279,348		2.00
	0		0	535,482		
	D - CHARGEABLE DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	19,754,275		1.00
	0		0	19,754,275		
	E - MALPRACTICE INSURANCE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	9,854,416		1.00
	0		0	9,854,416		
	F - DEPRECIATION					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	17,191,276		1.00
	0		0	17,191,276		
	G - PHYSICIAN FEES					
1.00	ADULTS & PEDIATRICS	30.00	0	1,931,566		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	663,547		2.00
3.00	SUBPROVIDER - IRF	41.00	0	108,853		3.00
4.00	OPERATING ROOM	50.00	0	618,885		4.00
5.00	RADIOLOGY-DIAGNOSTIC	54.00	0	119,000		5.00
6.00	LABORATORY	60.00	0	150,000		6.00
7.00	RESPIRATORY THERAPY	65.00	0	85,332		7.00
8.00	SLEEP LAB	65.01	0	110,000		8.00
9.00	ELECTROCARDIOLOGY	69.00	0	2,226,404		9.00
10.00	ELECTROENCEPHALOGRAPHY	70.00	0	1,534,033		10.00
11.00	RENAL DIALYSIS	74.00	0	103,600		11.00
12.00	EMERGENCY	91.00	0	563,000		12.00
13.00	DIABETES CENTER	91.02	0	5,004		13.00
14.00	HOME HEALTH AGENCY	101.00	0	32,008		14.00
	0		0	8,251,232		
	H - LABOR AND DELIVERY					
1.00	ADULTS & PEDIATRICS	30.00	3,190,297	0		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	3,337,696	0		2.00
	0		6,527,993	0		
	I - SOCIAL SERVICES					
1.00	SOCIAL SERVICE	17.00	53,707	0		1.00
	0		53,707	0		
	K - CHARGEABLE SUPPLIES					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,545,911		1.00
2.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	39,335,013		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
25.00		0.00	0	0		25.00
26.00		0.00	0	0		26.00
27.00		0.00	0	0		27.00
28.00		0.00	0	0		28.00

RECLASSIFICATIONS

Provider CCN: 14-0213

Period:
From 10/01/2020
To 09/30/2021

Worksheet A-6

Date/Time Prepared:
2/28/2022 12:24 pm

Increases					
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
29.00		0.00	0	0	29.00
30.00		0.00	0	0	30.00
31.00		0.00	0	0	31.00
32.00		0.00	0	0	32.00
33.00		0.00	0	0	33.00
0			0	40,880,924	
L - DIABETES MANAGEMENT					
1.00	ADULTS & PEDIATRICS	30.00	69,407	995	1.00
0			69,407	995	
M - DIETARY RECLASS					
1.00	CAFETERIA	11.00	1,652,231	1,744,425	1.00
0			1,652,231	1,744,425	
N - IMPLANTABLE DEVICES					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	22,339,160	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
0			0	22,339,160	
500.00	Grand Total: Increases		9,229,193	122,512,182	500.00

RECLASSIFICATIONS

Provider CCN: 14-0213

Period:
From 10/01/2020
To 09/30/2021

Worksheet A-6

Date/Time Prepared:
2/28/2022 12:24 pm

	Decreases						2/28/2022 12:24 pm
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - STERILE PROCESSING						
1.00	CENTRAL SERVICES & SUPPLY	14.00	925,855	1,959,997	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
	0		925,855	1,959,997			
	C - CAPITAL INSURANCE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	535,482	12		1.00
2.00		0.00	0	0	0		2.00
	0		0	535,482			
	D - CHARGEABLE DRUGS						
1.00	PHARMACY	15.00	0	19,754,275	0		1.00
	0		0	19,754,275			
	E - MALPRACTICE INSURANCE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	9,854,416	12		1.00
	0		0	9,854,416			
	F - DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	17,191,276	9		1.00
	0		0	17,191,276			
	G - PHYSICIAN FEES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	8,204,132	0		1.00
2.00	CLINIC	90.00	0	47,100	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
	0		0	8,251,232			
	H - LABOR AND DELIVERY						
1.00	NURSERY	43.00	6,527,993	0	0		1.00
2.00		0.00	0	0	0		2.00
	0		6,527,993	0			
	I - SOCIAL SERVICES						
1.00	ADMINISTRATIVE & GENERAL	5.00	53,707	0	0		1.00
	0		53,707	0			
	K - CHARGEABLE SUPPLIES						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	23,332	0		1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	627,192	0		2.00
3.00	PHARMACY	15.00	0	155,374	0		3.00
4.00	PARAMED ED PRGM	23.00	0	156,787	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	4,278,383	0		5.00
6.00	INTENSIVE CARE UNIT	31.00	0	1,605,741	0		6.00
7.00	SUBPROVIDER - IRF	41.00	0	198,504	0		7.00
8.00	NURSERY	43.00	0	280,627	0		8.00
9.00	OPERATING ROOM	50.00	0	13,298,195	0		9.00
10.00	RECOVERY ROOM	51.00	0	45,380	0		10.00
11.00	DELIVERY ROOM & LABOR ROOM	52.00	0	971,520	0		11.00
12.00	RADIOLOGY-DIAGNOSTIC	54.00	0	6,912,810	0		12.00
13.00	ULTRASOUND	54.01	0	199,754	0		13.00
14.00	CT SCAN	57.00	0	382,266	0		14.00
15.00	LABORATORY	60.00	0	8,743,767	0		15.00
16.00	RESPIRATORY THERAPY	65.00	0	350,793	0		16.00
17.00	PHYSICAL THERAPY	66.00	0	5,680	0		17.00
18.00	OCCUPATIONAL THERAPY	67.00	0	38,923	0		18.00
19.00	ELECTROCARDIOLOGY	69.00	0	36,778	0		19.00
20.00	ELECTROENCEPHALOGRAPHY	70.00	0	18,647	0		20.00
21.00	RENAL DIALYSIS	74.00	0	153,757	0		21.00
22.00	CLINIC	90.00	0	117,436	0		22.00
23.00	EMERGENCY	91.00	0	1,783,247	0		23.00
24.00	DIABETES CENTER	91.02	0	378	0		24.00
25.00	HOME HEALTH AGENCY	101.00	0	29,140	0		25.00
26.00	OPERATION OF PLANT	7.00	0	51,099	0		26.00
27.00	HOUSEKEEPING	9.00	0	15,642	0		27.00
28.00	DIETARY	10.00	0	44,369	0		28.00
29.00	NURSING ADMINISTRATION	13.00	0	30,152	0		29.00

RECLASSIFICATIONS

Provider CCN: 14-0213

Period:
From 10/01/2020
To 09/30/2021

Worksheet A-6

Date/Time Prepared:
2/28/2022 12:24 pm

Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
30.00	SLEEP LAB	65.01	0	30,264	0	30.00
31.00	BLOOD STORING PROCESSING & TRANS.	63.00	0	228,529	0	31.00
32.00	MRI	58.00	0	64,408	0	32.00
33.00	MEDICAL RECORDS & LIBRARY	16.00	0	2,050	0	33.00
			0	40,880,924		
L - DIABETES MANAGEMENT						
1.00	DIABETES CENTER	91.02	69,407	995	0	1.00
			69,407	995		
M - DIETARY RECLASS						
1.00	DIETARY	10.00	1,652,231	1,744,425	0	1.00
			1,652,231	1,744,425		
N - IMPLANTABLE DEVICES						
1.00	OPERATING ROOM	50.00	0	16,063,610	0	1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	5,722,645	0	2.00
3.00	CLINIC	90.00	0	552,905	0	3.00
			0	22,339,160		
500.00	Grand Total: Decreases		9,229,193	122,512,182		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0213

Period:
From 10/01/2020
To 09/30/2021Worksheet A-7
Part I
Date/Time Prepared:
2/28/2022 12:24 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	20,050,814	0	0	0	299,985	1.00	
2.00	Land Improvements	15,796,868	2,004,152	0	2,004,152	0	2.00	
3.00	Buildings and Fixtures	333,257,977	17,488,899	0	17,488,899	0	3.00	
4.00	Building Improvements	43,178,385	2,543,186	0	2,543,186	0	4.00	
5.00	Fixed Equipment	0	0	0	0	0	5.00	
6.00	Movable Equipment	250,366,108	16,297,473	0	16,297,473	0	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	662,650,152	38,333,710	0	38,333,710	299,985	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	662,650,152	38,333,710	0	38,333,710	299,985	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	19,750,829	0				1.00	
2.00	Land Improvements	17,801,020	0				2.00	
3.00	Buildings and Fixtures	350,746,876	0				3.00	
4.00	Building Improvements	45,721,571	0				4.00	
5.00	Fixed Equipment	0	0				5.00	
6.00	Movable Equipment	266,663,581	0				6.00	
7.00	HIT designated Assets	0	0				7.00	
8.00	Subtotal (sum of lines 1-7)	700,683,877	0				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	700,683,877	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0213

Period:
From 10/01/2020
To 09/30/2021Worksheet A-7
Part II
Date/Time Prepared:
2/28/2022 12:24 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	30,384,215	171,429	14,061,728	10,612,727	544,278	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	30,384,215	171,429	14,061,728	10,612,727	544,278	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	55,774,377				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	55,774,377				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0213

Period:
From 10/01/2020
To 09/30/2021Worksheet A-7
Part III
Date/Time Prepared:
2/28/2022 12:24 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	434,020,296	0	434,020,296	0.619424	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	266,663,581	0	266,663,581	0.380576	0	2.00
3.00	Total (sum of lines 1-2)	700,683,877	0	700,683,877	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	11,587,213	171,429	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	17,191,276	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	28,778,489	171,429	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	222,829	544,278	0	12,525,749	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	256,134	0	0	17,447,410	2.00
3.00	Total (sum of lines 1-2)	0	478,963	544,278	0	29,973,159	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0213

Period:
From 10/01/2020
To 09/30/2021

Worksheet A-8

Date/Time Prepared:
2/28/2022 12:24 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-7,631,023			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	4,727			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)			0*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT			0CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP			0CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist			0*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant			0	0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)			0ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest			0	0.00	0	32.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0213

Period:
From 10/01/2020
To 09/30/2021

Worksheet A-8

Date/Time Prepared:
2/28/2022 12:24 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
33.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.00
33.01	1996 DSR INTEXP	A	14,351	CAP REL COSTS-BLDG & FIXT	1.00	9	33.01
33.02	PROVIDER TAX ASSESSMENT IN A&G	B	-18,439,217	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	ADMINISTRATIVE MISC	B	-201,720	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	PHYSICIANS	A		ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	CONTRIBUTIONS EXPENSE	B	-89,155	ADMINISTRATIVE & GENERAL	5.00	9	33.05
33.06	BAD DEBTS	A	514,038	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	TELEPHONE BENEFITS	B	-21,280	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.07
33.08	TELEPHONE COSTS	A	-83,044	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	COMMUNITY RELATIONS	A	-1,541,089	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	OTHER REV - CAPITAL EXPENSE	B	-1,620,077	CAP REL COSTS-BLDG & FIXT	1.00	9	33.10
33.11	OTHER REV - EMPLOYEE BENEFIS	B	-67,140	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.11
33.12	OTHER REV A & G	B	-1,175,652	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13	OTHER REV - OPERATION & PLANT	B	-160	OPERATION OF PLANT	7.00	0	33.13
33.14	OTHER REV - CAF'-EMP & GUESTS	B	-1,657,789	CAFETERIA	11.00	0	33.14
33.15	OTHER REV - VENDING MACHINES	B		CAFETERIA	11.00	0	33.15
33.16	OTHER REVENUE-CENTRAL SUPPLY	B		CENTRAL SERVICES & SUPPLY	14.00	0	33.16
33.17	OTHER REV - PHARMACY	B		PHARMACY	15.00	0	33.17
33.18	OTHER REV - MED REC	B	-3,638	MEDICAL RECORDS & LIBRARY	16.00	0	33.18
33.19	OTHER REV - PARAMED ED PROGRAM	B	-198,974	PARAMED ED PRGM	23.00	0	33.19
33.20	OTHER REV - A & P	B		ADULTS & PEDIATRICS	30.00	0	33.20
33.21	OTHER REV - NUTRITION	B	-2,829	DIETARY	10.00	0	33.21
33.22	OTHER REV - HOUSEKEEPING	B	-1	HOUSEKEEPING	9.00	0	33.22
33.23	OTHER REV - NURSERY	B	-1,645	NURSERY	43.00	0	33.23
33.24	OTHER REV - OPERATING ROOM	B		OPERATING ROOM	50.00	0	33.24
33.25	OTHER REV - RADIOLOGY	B	-4,942	RADIOLOGY-DIAGNOSTIC	54.00	0	33.25
33.26	OTHER REV - LAB	B	-625	LABORATORY	60.00	0	33.26
33.27	OTHER REV - CARDIAC CATH	B	4,820	ELECTROCARDIOLOGY	69.00	0	33.27
33.28	OTHER REV - RESP THERAPY	B		RESPIRATORY THERAPY	65.00	0	33.28
33.29	OTHER REV - ER	B		EMERGENCY	91.00	0	33.29
33.30	OTHER REV - PSYCH	B		OP MENTAL HEALTH	91.01	0	33.30
33.31	INVESTMENT INCOME	B	-14,061,728	CAP REL COSTS-BLDG & FIXT	1.00	11	33.31
33.32	AHA & IHA DUES-POLITICAL LOBBY	B	-55,874	ADMINISTRATIVE & GENERAL	5.00	0	33.32
33.33	OTHER REV - CENTRAL SERVICES & SUPPL	B	-19,986	CENTRAL SERVICES & SUPPLY	14.00	0	33.33
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-46,339,652				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

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

Provider CCN: 14-0213

Period:
From 10/01/2020
To 09/30/2021

Worksheet A-8-1

Date/Time Prepared:
2/28/2022 12:24 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	MANAGEMENT FEE	8,522,097	8,517,370	1.00
2.00	0.00		0	0	0	2.00
3.00	0.00		0	0	0	3.00
4.00	0.00		0	0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			8,522,097	8,517,370	5.00

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

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

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

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

6.00	G	SILVER CROSS HO	100.00	SILVER CROSS HO	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:	FINANCIAL				100.00

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

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

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

Provider CCN: 14-0213

Period:
From 10/01/2020
To 09/30/2021

Worksheet A-8-1

Date/Time Prepared:
2/28/2022 12:24 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	4,727	0		1.00
2.00	0	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
5.00	4,727			5.00

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

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

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0213

Period:
From 10/01/2020
To 09/30/2021

Worksheet A-8-2

Date/Time Prepared:
2/28/2022 12:24 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	211,500	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	1,931,566	1,812,741	118,825	177,200	557	2.00
3.00	31.00	INTENSIVE CARE UNIT	663,547	603,547	60,000	154,100	562	3.00
4.00	40.00	SUBPROVIDER - IPF	0	0	0	154,100	0	4.00
5.00	41.00	SUBPROVIDER - IRF	108,853	108,853	0	208,000	0	5.00
6.00	50.00	OPERATING ROOM	618,885	496,510	122,375	177,200	895	6.00
7.00	65.00	RESPIRATORY THERAPY	85,332	70,000	15,332	177,200	142	7.00
8.00	69.00	ELECTROCARDIOLOGY	2,226,404	2,186,404	40,000	177,200	282	8.00
9.00	70.00	ELECTROENCEPHALOGRAPHY	1,534,033	1,461,700	72,333	177,200	1,355	9.00
10.00	74.00	RENAL DIALYSIS	103,600	0	103,600	177,200	1,009	10.00
11.00	90.00	CLINIC	-47,100	-61,500	14,400	177,200	60	11.00
12.00	91.00	EMERGENCY	563,000	485,250	77,750	177,200	569	12.00
13.00	65.01	SLEEP LAB	110,000	110,000	0	215,700	0	13.00
14.00	60.00	LABORATORY	150,000	0	150,000	177,200	1,041	14.00
15.00	91.02	DIABETES CENTER	5,004	0	5,004	177,200	60	15.00
16.00	54.00	RADIOLOGY-DIAGNOSTIC	119,000	0	119,000	177,200	400	16.00
200.00			8,172,124	7,273,505	898,619		6,932	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	47,452	2,373	0	0	0	2.00
3.00	31.00	INTENSIVE CARE UNIT	41,637	2,082	0	0	0	3.00
4.00	40.00	SUBPROVIDER - IPF	0	0	0	0	0	4.00
5.00	41.00	SUBPROVIDER - IRF	0	0	0	0	0	5.00
6.00	50.00	OPERATING ROOM	76,247	3,812	0	0	0	6.00
7.00	65.00	RESPIRATORY THERAPY	12,097	605	0	0	0	7.00
8.00	69.00	ELECTROCARDIOLOGY	24,024	1,201	0	0	0	8.00
9.00	70.00	ELECTROENCEPHALOGRAPHY	115,436	5,772	0	0	0	9.00
10.00	74.00	RENAL DIALYSIS	85,959	4,298	0	0	0	10.00
11.00	90.00	CLINIC	5,112	256	0	0	0	11.00
12.00	91.00	EMERGENCY	48,474	2,424	0	0	0	12.00
13.00	65.01	SLEEP LAB	0	0	0	0	0	13.00
14.00	60.00	LABORATORY	88,685	4,434	0	0	0	14.00
15.00	91.02	DIABETES CENTER	5,112	256	0	0	0	15.00
16.00	54.00	RADIOLOGY-DIAGNOSTIC	34,077	1,704	0	0	0	16.00
200.00			584,312	29,217	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	47,452	71,373	1,884,114		2.00
3.00	31.00	INTENSIVE CARE UNIT	0	41,637	18,363	621,910		3.00
4.00	40.00	SUBPROVIDER - IPF	0	0	0	0		4.00
5.00	41.00	SUBPROVIDER - IRF	0	0	0	108,853		5.00
6.00	50.00	OPERATING ROOM	0	76,247	46,128	542,638		6.00
7.00	65.00	RESPIRATORY THERAPY	0	12,097	3,235	73,235		7.00
8.00	69.00	ELECTROCARDIOLOGY	0	24,024	15,976	2,202,380		8.00
9.00	70.00	ELECTROENCEPHALOGRAPHY	0	115,436	0	1,461,700		9.00
10.00	74.00	RENAL DIALYSIS	0	85,959	17,641	17,641		10.00
11.00	90.00	CLINIC	0	5,112	9,288	-52,212		11.00
12.00	91.00	EMERGENCY	0	48,474	29,276	514,526		12.00
13.00	65.01	SLEEP LAB	0	0	0	110,000		13.00
14.00	60.00	LABORATORY	0	88,685	61,315	61,315		14.00
15.00	91.02	DIABETES CENTER	0	5,112	0	0		15.00
16.00	54.00	RADIOLOGY-DIAGNOSTIC	0	34,077	84,923	84,923		16.00
200.00			0	584,312	357,518	7,631,023		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0213

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part I
Date/Time Prepared:
2/28/2022 12:24 pm

Cost Center Description			Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	12,525,749	12,525,749				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	17,447,410		17,447,410			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	42,002,144	43,039	0	42,045,183		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	68,683,060	3,109,416	10,993,688	6,277,544	89,063,708	5.00
7.00	00700	OPERATION OF PLANT	11,451,210	142,908	143,927	1,038,272	12,776,317	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	170,112	49,157	0	20,806	240,075	8.00
9.00	00900	HOUSEKEEPING	5,196,087	121,868	2,534	792,411	6,112,900	9.00
10.00	01000	DIETARY	1,443,218	484,339	5,831	204,366	2,137,754	10.00
11.00	01100	CAFETERIA	1,738,867	0	13,290	465,749	2,217,906	11.00
13.00	01300	NURSING ADMINISTRATION	3,488,606	61,307	74,723	955,772	4,580,408	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	728,447	390,822	166,219	209,431	1,494,919	14.00
15.00	01500	PHARMACY	7,453,740	161,326	8,854	1,227,132	8,851,052	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,414,302	22,830	1,658	824,891	4,263,681	16.00
17.00	01700	SOCIAL SERVICE	53,707	0	0	15,140	68,847	17.00
23.00	02300	PARAMED ED PRGM	425,124	17,863	14,106	115,647	572,740	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	37,006,564	3,049,048	364,427	9,693,615	50,113,654	30.00
31.00	03100	INTENSIVE CARE UNIT	8,941,317	361,917	190,454	2,080,859	11,574,547	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	4,909,707	429,917	14,192	1,216,657	6,570,473	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	5,067,405	970,447	31,029	1,221,211	7,290,092	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	21,227,696	1,405,843	3,010,480	3,239,903	28,883,922	50.00
51.00	05100	RECOVERY ROOM	1,588,772	92,451	312	431,607	2,113,142	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,673,148	0	85,005	957,309	4,715,462	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	14,320,065	502,288	1,191,446	2,631,687	18,645,486	54.00
54.01	05401	ULTRASOUND	1,535,144	63,993	34,647	370,485	2,004,269	54.01
57.00	05700	CT SCAN	2,179,099	77,678	305,546	372,611	2,934,934	57.00
58.00	05800	MRI	1,207,690	74,012	19,459	215,474	1,516,635	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	10,364,202	12,769	227,957	1,310,011	11,914,939	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING PROCESSING & TRANS.	2,054,063	0	19,450	76,105	2,149,618	63.00
65.00	06500	RESPIRATORY THERAPY	2,852,143	41,888	48,623	612,023	3,554,677	65.00
65.01	06501	SLEEP LAB	392,044	0	2,633	70,728	465,405	65.01
66.00	06600	PHYSICAL THERAPY	1,965,117	5,308	3,525	462,139	2,436,089	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,288,051	0	30,380	532,735	2,851,166	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,017,436	31,037	166,148	487,044	2,701,665	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	238,330	22,169	7,362	43,917	311,778	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	39,335,013	0	0	0	39,335,013	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	22,339,160	0	0	0	22,339,160	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	19,754,275	0	0	0	19,754,275	73.00
74.00	07400	RENAL DIALYSIS	608,984	61,733	7,971	132,762	811,450	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	1,056,215	0	977	179,020	1,236,212	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	0	90.02
90.03	09003	WOMENS HEALTH	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	11,140,263	679,814	259,444	2,572,125	14,651,646	91.00
91.01	09101	OP MENTAL HEALTH	0	0	0	0	0	91.01
91.02	09102	DIABETES CENTER	296,487	0	245	81,110	377,842	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	3,637,067	0	868	900,185	4,538,120	101.00
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0213

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part I
Date/Time Prepared:
2/28/2022 12:24 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	
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	398,217,240	12,487,187	17,447,410	42,038,483	398,171,978	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	22,640	38,562	0	6,382	67,584	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	FOUNDATION	1,129	0	0	318	1,447	192.01
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	398,241,009	12,525,749	17,447,410	42,045,183	398,241,009	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0213

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part I
Date/Time Prepared:
2/28/2022 12:24 pm

Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	89,063,708					5.00
7.00	00700	OPERATION OF PLANT	3,680,435	16,456,752				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	69,158	87,641	396,874			8.00
9.00	00900	HOUSEKEEPING	1,760,925	217,277	0	8,091,102		9.00
10.00	01000	DIETARY	615,816	863,522	0	432,573	4,049,665	10.00
11.00	01100	CAFETERIA	638,906	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,319,464	109,304	0	54,755	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	430,637	696,792	479	349,051	0	14.00
15.00	01500	PHARMACY	2,549,696	287,625	0	144,083	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,228,226	40,704	0	20,390	0	16.00
17.00	01700	SOCIAL SERVICE	19,833	0	0	0	0	17.00
23.00	02300	PARAMED ED PRGM	164,987	31,849	10,005	15,954	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	14,436,018	5,436,115	165,130	2,723,168	2,617,092	30.00
31.00	03100	INTENSIVE CARE UNIT	3,334,245	645,257	27,465	323,235	728,479	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	1,892,736	766,494	9,474	383,968	704,094	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	2,100,035	1,730,199	0	866,726	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	8,320,505	2,506,461	60,392	1,255,587	0	50.00
51.00	05100	RECOVERY ROOM	608,726	164,830	13,896	82,570	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,358,369	0	23,021	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,371,149	895,523	20,958	448,603	0	54.00
54.01	05401	ULTRASOUND	577,364	114,092	2,142	57,153	0	54.01
57.00	05700	CT SCAN	845,458	138,492	3,206	69,376	0	57.00
58.00	05800	MRI	436,892	131,955	5,361	66,102	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	3,432,301	22,765	0	11,404	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING PROCESSING & TRANS.	619,234	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	1,023,985	74,681	0	37,411	0	65.00
65.01	06501	SLEEP LAB	134,068	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	701,757	9,463	0	4,741	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	821,327	0	4,537	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	778,261	55,336	328	27,720	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	89,813	39,526	0	19,800	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	11,331,119	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,435,175	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,690,555	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	233,752	110,064	0	55,135	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	356,112	0	185	0	0	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	0	90.02
90.03	09003	WOMENS HEALTH	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	4,220,656	1,212,033	50,295	607,156	0	91.00
91.01	09101	OP MENTAL HEALTH	0	0	0	0	0	91.01
91.02	09102	DIABETES CENTER	108,844	0	0	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	1,307,283	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	89,043,822	16,388,000	396,874	8,056,661	4,049,665	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	19,469	68,752	0	34,441	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0213

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part I
Date/Time Prepared:
2/28/2022 12:24 pm

Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
192.01	19201	FOUNDATION	417	0	0	0	0	192.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	89,063,708	16,456,752	396,874	8,091,102	4,049,665	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0213

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part I
Date/Time Prepared:
2/28/2022 12:24 pm

Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	2,856,812					11.00
13.00	01300	NURSING ADMINISTRATION	79,522	6,143,453				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	71,569	0	3,043,447			14.00
15.00	01500	PHARMACY	87,474	0	0	11,919,930		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	87,474	0	0	0	5,640,475	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
23.00	02300	PARAMED ED PRGM	9,940	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	815,096	3,522,648	0	0	2,411,527	30.00
31.00	03100	INTENSIVE CARE UNIT	165,007	713,349	0	0	687,103	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	107,354	465,822	0	0	174,385	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	244,529	1,059,381	0	0	241,066	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	250,493	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	27,833	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	228,624	0	0	0	0	54.00
54.01	05401	ULTRASOUND	29,821	0	0	0	0	54.01
57.00	05700	CT SCAN	31,809	0	0	0	0	57.00
58.00	05800	MRI	15,904	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	141,151	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING PROCESSING & TRANS.	7,952	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	59,641	0	0	0	0	65.00
65.01	06501	SLEEP LAB	7,952	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	37,773	0	0	0	519,241	66.00
67.00	06700	OCCUPATIONAL THERAPY	45,725	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	43,737	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	5,964	0	0	0	120,605	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	3,043,447	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	11,919,930	0	73.00
74.00	07400	RENAL DIALYSIS	9,940	42,516	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	13,916	0	0	0	22,758	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	0	90.02
90.03	09003	WOMENS HEALTH	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	222,660	0	0	0	1,463,790	91.00
91.01	09101	OP MENTAL HEALTH	0	0	0	0	0	91.01
91.02	09102	DIABETES CENTER	7,952	38,117	0	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	301,620	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,856,812	6,143,453	3,043,447	11,919,930	5,640,475	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0213

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part I
Date/Time Prepared:
2/28/2022 12:24 pm

Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	FOUNDATION	0	0	0	0	0	192.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,856,812	6,143,453	3,043,447	11,919,930	5,640,475	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0213

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part I
Date/Time Prepared:
2/28/2022 12:24 pm

Cost Center Description			SOCIAL SERVICE	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	23.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	88,680					17.00
23.00	02300	PARAMED ED PRGM	0	805,475				23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	77,028	0	82,317,476	0	82,317,476	30.00
31.00	03100	INTENSIVE CARE UNIT	4,724	0	18,203,411	0	18,203,411	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	11,074,800	0	11,074,800	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	13,532,028	0	13,532,028	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	41,277,360	0	41,277,360	50.00
51.00	05100	RECOVERY ROOM	0	0	3,010,997	0	3,010,997	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	24,751	6,121,603	0	6,121,603	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	25,610,343	0	25,610,343	54.00
54.01	05401	ULTRASOUND	0	0	2,784,841	0	2,784,841	54.01
57.00	05700	CT SCAN	0	0	4,023,275	0	4,023,275	57.00
58.00	05800	MRI	0	0	2,172,849	0	2,172,849	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	15,522,560	0	15,522,560	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0	0	2,776,804	0	2,776,804	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	4,750,395	0	4,750,395	65.00
65.01	06501	SLEEP LAB	0	0	607,425	0	607,425	65.01
66.00	06600	PHYSICAL THERAPY	0	0	3,709,064	0	3,709,064	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	3,722,755	0	3,722,755	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	24,751	3,631,798	0	3,631,798	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	587,486	0	587,486	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	53,709,579	0	53,709,579	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	28,774,335	0	28,774,335	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	37,364,760	0	37,364,760	73.00
74.00	07400	RENAL DIALYSIS	0	0	1,262,857	0	1,262,857	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	1,102	0	1,630,285	0	1,630,285	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	0	90.02
90.03	09003	WOMENS HEALTH	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	5,826	755,973	23,190,035	0	23,190,035	91.00
91.01	09101	OP MENTAL HEALTH	0	0	0	0	0	91.01
91.02	09102	DIABETES CENTER	0	0	532,755	0	532,755	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	6,147,023	0	6,147,023	101.00
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	88,680	805,475	398,048,899	0	398,048,899	118.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0213

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part I
Date/Time Prepared:
2/28/2022 12:24 pm

Cost Center Description			SOCIAL SERVICE	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	23.00	24.00	25.00	26.00	
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	190,246	0	190,246	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	FOUNDATION	0	0	1,864	0	1,864	192.01
200.00		Cross Foot Adjustments		0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	88,680	805,475	398,241,009	0	398,241,009	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0213

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part II
Date/Time Prepared:
2/28/2022 12:24 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	43,039	0	43,039	43,039
5.00	00500	ADMINISTRATIVE & GENERAL	0	3,109,416	10,993,688	14,103,104	6,436
7.00	00700	OPERATION OF PLANT	0	142,908	143,927	286,835	1,064
8.00	00800	LAUNDRY & LINEN SERVICE	0	49,157	0	49,157	21
9.00	00900	HOUSEKEEPING	0	121,868	2,534	124,402	812
10.00	01000	DIETARY	0	484,339	5,831	490,170	210
11.00	01100	CAFETERIA	0	0	13,290	13,290	477
13.00	01300	NURSING ADMINISTRATION	0	61,307	74,723	136,030	980
14.00	01400	CENTRAL SERVICES & SUPPLY	0	390,822	166,219	557,041	215
15.00	01500	PHARMACY	0	161,326	8,854	170,180	1,258
16.00	01600	MEDICAL RECORDS & LIBRARY	0	22,830	1,658	24,488	846
17.00	01700	SOCIAL SERVICE	0	0	0	0	16
23.00	02300	PARAMED ED PRGM	0	17,863	14,106	31,969	119
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	3,049,048	364,427	3,413,475	9,872
31.00	03100	INTENSIVE CARE UNIT	0	361,917	190,454	552,371	2,133
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0
41.00	04100	SUBPROVIDER - IRF	0	429,917	14,192	444,109	1,247
42.00	04200	SUBPROVIDER	0	0	0	0	0
43.00	04300	NURSERY	0	970,447	31,029	1,001,476	1,252
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0
45.00	04500	NURSING FACILITY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	1,405,843	3,010,480	4,416,323	3,322
51.00	05100	RECOVERY ROOM	0	92,451	312	92,763	442
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	85,005	85,005	981
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	502,288	1,191,446	1,693,734	2,698
54.01	05401	ULTRASOUND	0	63,993	34,647	98,640	380
57.00	05700	CT SCAN	0	77,678	305,546	383,224	382
58.00	05800	MRI	0	74,012	19,459	93,471	221
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	0	12,769	227,957	240,726	1,343
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0	0	19,450	19,450	78
65.00	06500	RESPIRATORY THERAPY	0	41,888	48,623	90,511	627
65.01	06501	SLEEP LAB	0	0	2,633	2,633	73
66.00	06600	PHYSICAL THERAPY	0	5,308	3,525	8,833	474
67.00	06700	OCCUPATIONAL THERAPY	0	0	30,380	30,380	546
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	0	31,037	166,148	197,185	499
70.00	07000	ELECTROENCEPHALOGRAPHY	0	22,169	7,362	29,531	45
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
74.00	07400	RENAL DIALYSIS	0	61,733	7,971	69,704	136
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00	09000	CLINIC	0	0	977	977	184
90.01	09001	HOMER GLEN LAB	0	0	0	0	0
90.02	09002	HOMER GLEN FEC	0	0	0	0	0
90.03	09003	WOMENS HEALTH	0	0	0	0	0
91.00	09100	EMERGENCY	0	679,814	259,444	939,258	2,637
91.01	09101	OP MENTAL HEALTH	0	0	0	0	0
91.02	09102	DIABETES CENTER	0	0	245	245	83
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0
99.00	09900	CMHC	0	0	0	0	0
99.10	09910	CORF	0	0	0	0	0
101.00	10100	HOME HEALTH AGENCY	0	0	868	868	923
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0
111.00	11100	ISLET ACQUISITION	0	0	0	0	0

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0213

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part II
Date/Time Prepared:
2/28/2022 12:24 pm

Cost Center Description			Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	2A	4.00	
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	12,487,187	17,447,410	29,934,597	43,032	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	38,562	0	38,562	7	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	FOUNDATION	0	0	0	0	0	192.01
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	12,525,749	17,447,410	29,973,159	43,039	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0213

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part II
Date/Time Prepared:
2/28/2022 12:24 pm

Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	14,109,540					5.00
7.00	00700	OPERATION OF PLANT	583,060	870,959				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	10,956	4,638	64,772			8.00
9.00	00900	HOUSEKEEPING	278,968	11,499	0	415,681		9.00
10.00	01000	DIETARY	97,559	45,701	0	22,223	655,863	10.00
11.00	01100	CAFETERIA	101,216	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	209,031	5,785	0	2,813	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	68,222	36,877	78	17,933	0	14.00
15.00	01500	PHARMACY	403,927	15,222	0	7,402	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	194,577	2,154	0	1,048	0	16.00
17.00	01700	SOCIAL SERVICE	3,142	0	0	0	0	17.00
23.00	02300	PARAMED ED PRGM	26,138	1,686	1,633	820	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,286,912	287,701	26,952	139,903	423,850	30.00
31.00	03100	INTENSIVE CARE UNIT	528,216	34,150	4,482	16,606	117,981	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	299,850	40,566	1,546	19,726	114,032	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	332,691	91,569	0	44,528	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,318,147	132,652	9,856	64,506	0	50.00
51.00	05100	RECOVERY ROOM	96,435	8,723	2,268	4,242	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	215,195	0	3,757	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	850,905	47,395	3,420	23,047	0	54.00
54.01	05401	ULTRASOUND	91,467	6,038	350	2,936	0	54.01
57.00	05700	CT SCAN	133,939	7,330	523	3,564	0	57.00
58.00	05800	MRI	69,213	6,984	875	3,396	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	543,750	1,205	0	586	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING PROCESSING & TRANS.	98,100	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	162,221	3,952	0	1,922	0	65.00
65.01	06501	SLEEP LAB	21,239	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	111,173	501	0	244	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	130,116	0	740	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	123,293	2,929	54	1,424	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	14,228	2,092	0	1,017	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,795,093	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,019,470	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	901,506	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	37,031	5,825	0	2,833	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	56,416	0	30	0	0	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	0	90.02
90.03	09003	WOMENS HEALTH	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	668,643	64,146	8,208	31,193	0	91.00
91.01	09101	OP MENTAL HEALTH	0	0	0	0	0	91.01
91.02	09102	DIABETES CENTER	17,243	0	0	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	207,102	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,106,390	867,320	64,772	413,912	655,863	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	3,084	3,639	0	1,769	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0213

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part II
Date/Time Prepared:
2/28/2022 12:24 pm

Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
192.01	19201	FOUNDATION	66	0	0	0	0	192.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	14,109,540	870,959	64,772	415,681	655,863	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0213

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part II
Date/Time Prepared:
2/28/2022 12:24 pm

Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	114,983					11.00
13.00	01300	NURSING ADMINISTRATION	3,201	357,840				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,881	0	683,247			14.00
15.00	01500	PHARMACY	3,521	0	0	601,510		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,521	0	0	0	226,634	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
23.00	02300	PARAMED ED PRGM	400	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	32,808	205,185	0	0	96,895	30.00
31.00	03100	INTENSIVE CARE UNIT	6,641	41,551	0	0	27,608	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	4,321	27,133	0	0	7,007	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	9,842	61,706	0	0	9,686	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	10,082	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	1,120	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	9,202	0	0	0	0	54.00
54.01	05401	ULTRASOUND	1,200	0	0	0	0	54.01
57.00	05700	CT SCAN	1,280	0	0	0	0	57.00
58.00	05800	MRI	640	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	5,681	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING PROCESSING & TRANS.	320	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	2,400	0	0	0	0	65.00
65.01	06501	SLEEP LAB	320	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	1,520	0	0	0	20,863	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,840	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,760	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	240	0	0	0	4,846	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	683,247	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	601,510	0	73.00
74.00	07400	RENAL DIALYSIS	400	2,476	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	560	0	0	0	914	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	0	90.02
90.03	09003	WOMENS HEALTH	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	8,962	0	0	0	58,815	91.00
91.01	09101	OP MENTAL HEALTH	0	0	0	0	0	91.01
91.02	09102	DIABETES CENTER	320	2,220	0	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	17,569	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	114,983	357,840	683,247	601,510	226,634	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0213

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part II
Date/Time Prepared:
2/28/2022 12:24 pm

Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	FOUNDATION	0	0	0	0	0	192.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	114,983	357,840	683,247	601,510	226,634	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0213

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part II
Date/Time Prepared:
2/28/2022 12:24 pm

Cost Center Description			SOCIAL SERVICE	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	23.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	3,158					17.00
23.00	02300	PARAMED ED PRGM	0	62,765				23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,744		6,926,297	0	6,926,297	30.00
31.00	03100	INTENSIVE CARE UNIT	168		1,331,907	0	1,331,907	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	0		0	0	0	33.00
40.00	04000	SUBPROVIDER - IPF	0		0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0		959,537	0	959,537	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	42.00
43.00	04300	NURSERY	0		1,552,750	0	1,552,750	43.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
45.00	04500	NURSING FACILITY	0		0	0	0	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0		5,954,888	0	5,954,888	50.00
51.00	05100	RECOVERY ROOM	0		205,993	0	205,993	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		304,938	0	304,938	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		2,630,401	0	2,630,401	54.00
54.01	05401	ULTRASOUND	0		201,011	0	201,011	54.01
57.00	05700	CT SCAN	0		530,242	0	530,242	57.00
58.00	05800	MRI	0		174,800	0	174,800	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	0		793,291	0	793,291	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0		117,948	0	117,948	63.00
65.00	06500	RESPIRATORY THERAPY	0		261,633	0	261,633	65.00
65.01	06501	SLEEP LAB	0		24,265	0	24,265	65.01
66.00	06600	PHYSICAL THERAPY	0		143,608	0	143,608	66.00
67.00	06700	OCCUPATIONAL THERAPY	0		163,622	0	163,622	67.00
68.00	06800	SPEECH PATHOLOGY	0		0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0		327,144	0	327,144	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		51,999	0	51,999	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		2,478,340	0	2,478,340	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		1,019,470	0	1,019,470	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		1,503,016	0	1,503,016	73.00
74.00	07400	RENAL DIALYSIS	0		118,405	0	118,405	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000	CLINIC	39		59,120	0	59,120	90.00
90.01	09001	HOMER GLEN LAB	0		0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0		0	0	0	90.02
90.03	09003	WOMENS HEALTH	0		0	0	0	90.03
91.00	09100	EMERGENCY	207		1,782,069	0	1,782,069	91.00
91.01	09101	OP MENTAL HEALTH	0		0	0	0	91.01
91.02	09102	DIABETES CENTER	0		20,111	0	20,111	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0		0	0	0	94.00
99.00	09900	CMHC	0		0	0	0	99.00
99.10	09910	CORF	0		0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0		226,462	0	226,462	101.00
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0		0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0		0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0		0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,158	0	29,863,267	0	29,863,267	118.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0213

Period:
From 10/01/2020
To 09/30/2021Worksheet B
Part II
Date/Time Prepared:
2/28/2022 12:24 pm

Cost Center Description			SOCIAL SERVICE	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	23.00	24.00	25.00	26.00	
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0		47,061	0	47,061	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0		0	0	0	192.00
192.01	19201	FOUNDATION	0		66	0	66	192.01
200.00		Cross Foot Adjustments		62,765	62,765	0	62,765	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	3,158	62,765	29,973,159	0	29,973,159	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0213

Period:
From 10/01/2020
To 09/30/2021

Worksheet B-1

Date/Time Prepared:
2/28/2022 12:24 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	587,600					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		18,978,512				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,019	0	149,154,099			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	145,867	11,958,441	22,269,403	-89,063,708	309,177,301	5.00
7.00	00700	OPERATION OF PLANT	6,704	156,557	3,683,240	0	12,776,317	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,306	0	73,807	0	240,075	8.00
9.00	00900	HOUSEKEEPING	5,717	2,756	2,811,054	0	6,112,900	9.00
10.00	01000	DIETARY	22,721	6,343	724,981	0	2,137,754	10.00
11.00	01100	CAFETERIA	0	14,456	1,652,231	0	2,217,906	11.00
13.00	01300	NURSING ADMINISTRATION	2,876	81,280	3,390,572	0	4,580,408	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	18,334	180,806	742,952	0	1,494,919	14.00
15.00	01500	PHARMACY	7,568	9,631	4,353,215	0	8,851,052	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,071	1,803	2,926,276	0	4,263,681	16.00
17.00	01700	SOCIAL SERVICE	0	0	53,707	0	68,847	17.00
23.00	02300	PARAMED PRGM	838	15,344	410,255	0	572,740	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	143,035	396,408	34,387,875	0	50,113,654	30.00
31.00	03100	INTENSIVE CARE UNIT	16,978	207,167	7,381,785	0	11,574,547	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	20,168	15,437	4,316,054	0	6,570,473	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	45,525	33,752	4,332,211	0	7,290,092	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	65,950	3,274,667	11,493,459	0	28,883,922	50.00
51.00	05100	RECOVERY ROOM	4,337	339	1,531,112	0	2,113,142	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	92,465	3,396,025	0	4,715,462	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	23,563	1,296,002	9,335,831	0	18,645,486	54.00
54.01	05401	ULTRASOUND	3,002	37,687	1,314,283	0	2,004,269	54.01
57.00	05700	CT SCAN	3,644	332,359	1,321,825	0	2,934,934	57.00
58.00	05800	MRI	3,472	21,167	764,389	0	1,516,635	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	599	247,962	4,647,224	0	11,914,939	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0	21,157	269,982	0	2,149,618	63.00
65.00	06500	RESPIRATORY THERAPY	1,965	52,890	2,171,134	0	3,554,677	65.00
65.01	06501	SLEEP LAB	0	2,864	250,905	0	465,405	65.01
66.00	06600	PHYSICAL THERAPY	249	3,834	1,639,423	0	2,436,089	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	33,046	1,889,861	0	2,851,166	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,456	180,728	1,727,773	0	2,701,665	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,040	8,008	155,794	0	311,778	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	39,335,013	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	22,339,160	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	19,754,275	73.00
74.00	07400	RENAL DIALYSIS	2,896	8,671	470,969	0	811,450	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	1,063	635,068	0	1,236,212	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	0	90.02
90.03	09003	WOMENS HEALTH	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	31,891	282,212	9,124,538	0	14,651,646	91.00
91.01	09101	OP MENTAL HEALTH	0	0	0	0	0	91.01
91.02	09102	DIABETES CENTER	0	266	287,736	0	377,842	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	944	3,193,381	0	4,538,120	101.00
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0213

Period:
From 10/01/2020
To 09/30/2021

Worksheet B-1

Date/Time Prepared:
2/28/2022 12:24 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5A	5.00	
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	585,791	18,978,512	149,130,330	-89,063,708	309,108,270	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	1,809	0	22,640	0	67,584	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	FOUNDATION	0	0	1,129	0	1,447	192.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	12,525,749	17,447,410	42,045,183		89,063,708	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	21.316795	0.919324	0.281891		0.288067	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			43,039		14,109,540	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000289		0.045636	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0213

Period:
From 10/01/2020
To 09/30/2021

Worksheet B-1

Date/Time Prepared:
2/28/2022 12:24 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (NUMBER HOUSED)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	433,010				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,306	2,424,197			8.00
9.00	00900	HOUSEKEEPING	5,717	0	424,987		9.00
10.00	01000	DIETARY	22,721	0	22,721	281,995	10.00
11.00	01100	CAFETERIA	0	0	0	1,437	11.00
13.00	01300	NURSING ADMINISTRATION	2,876	0	2,876	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	18,334	2,924	18,334	0	14.00
15.00	01500	PHARMACY	7,568	0	7,568	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,071	0	1,071	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
23.00	02300	PARAMED ED PRGM	838	61,111	838	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	143,035	1,008,659	143,035	182,239	30.00
31.00	03100	INTENSIVE CARE UNIT	16,978	167,761	16,978	50,727	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	33.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	20,168	57,872	20,168	49,029	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	42.00
43.00	04300	NURSERY	45,525	0	45,525	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	65,950	368,885	65,950	0	50.00
51.00	05100	RECOVERY ROOM	4,337	84,880	4,337	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	140,615	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	23,563	128,015	23,563	0	54.00
54.01	05401	ULTRASOUND	3,002	13,085	3,002	0	54.01
57.00	05700	CT SCAN	3,644	19,580	3,644	0	57.00
58.00	05800	MRI	3,472	32,746	3,472	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	599	0	599	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	1,965	0	1,965	0	65.00
65.01	06501	SLEEP LAB	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	249	0	249	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	27,713	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,456	2,006	1,456	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,040	0	1,040	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	2,896	0	2,896	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	0	1,130	0	0	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	90.02
90.03	09003	WOMENS HEALTH	0	0	0	0	90.03
91.00	09100	EMERGENCY	31,891	307,215	31,891	0	91.00
91.01	09101	OP MENTAL HEALTH	0	0	0	0	91.01
91.02	09102	DIABETES CENTER	0	0	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	94.00
99.00	09900	CMHC	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	431,201	2,424,197	423,178	281,995	1,437

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0213

Period:
From 10/01/2020
To 09/30/2021

Worksheet B-1

Date/Time Prepared:
2/28/2022 12:24 pm

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (NUMBER HOUSED)	
		7.00	8.00	9.00	10.00	11.00	
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	1,809	0	1,809	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	192.00
192.01	19201	FOUNDATION	0	0	0	0	192.01
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	16,456,752	396,874	8,091,102	4,049,665	2,856,812
203.00		Unit cost multiplier (Wkst. B, Part I)	38.005478	0.163714	19.038469	14.360769	1,988.038970
204.00		Cost to be allocated (per Wkst. B, Part II)	870,959	64,772	415,681	655,863	114,983
205.00		Unit cost multiplier (Wkst. B, Part II)	2.011406	0.026719	0.978103	2.325797	80.016006
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)					
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)					

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0213

Period:
From 10/01/2020
To 09/30/2021

Worksheet B-1

Date/Time Prepared:
2/28/2022 12:24 pm

Cost Center Description			NURSING ADMINISTRATION (DIRECT NRS ING)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	
			13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	1,487,469					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	42,999,659				14.00
15.00	01500	PHARMACY	0	0	19,744,064			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	38,911		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	2,816	17.00
23.00	02300	PARAMED ED PRGM	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	852,913	0	0	16,636	2,446	30.00
31.00	03100	INTENSIVE CARE UNIT	172,718	0	0	4,740	150	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	112,786	0	0	1,203	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	256,500	0	0	1,663	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	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
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
65.01	06501	SLEEP LAB	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	3,582	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	832	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	42,999,659	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	19,744,064	0	0	73.00
74.00	07400	RENAL DIALYSIS	10,294	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	157	35	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	0	90.02
90.03	09003	WOMENS HEALTH	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	0	10,098	185	91.00
91.01	09101	OP MENTAL HEALTH	0	0	0	0	0	91.01
91.02	09102	DIABETES CENTER	9,229	0	0	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	73,029	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,487,469	42,999,659	19,744,064	38,911	2,816	118.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0213

Period:
From 10/01/2020
To 09/30/2021

Worksheet B-1

Date/Time Prepared:
2/28/2022 12:24 pm

Cost Center Description			NURSING ADMINISTRATION (DIRECT NRS ING)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	
			13.00	14.00	15.00	16.00	17.00	
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	FOUNDATION	0	0	0	0	0	192.01
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	6,143,453	3,043,447	11,919,930	5,640,475	88,680	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	4.130139	0.070778	0.603722	144.958367	31.491477	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	357,840	683,247	601,510	226,634	3,158	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.240570	0.015890	0.030465	5.824420	1.121449	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0213

Period:
From 10/01/2020
To 09/30/2021

Worksheet B-1

Date/Time Prepared:
2/28/2022 12:24 pm

Cost Center Description		PARAMED ED PRGM (ASSIGNED TIME)	
		23.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
23.00	02300	PARAMED ED PRGM	23.00
		8,559	
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	33.00
40.00	04000	SUBPROVIDER - IPF	40.00
41.00	04100	SUBPROVIDER - IRF	41.00
42.00	04200	SUBPROVIDER	42.00
43.00	04300	NURSERY	43.00
44.00	04400	SKILLED NURSING FACILITY	44.00
45.00	04500	NURSING FACILITY	45.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
51.00	05100	RECOVERY ROOM	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
54.01	05401	ULTRASOUND	54.01
57.00	05700	CT SCAN	57.00
58.00	05800	MRI	58.00
59.00	05900	CARDIAC CATHETERIZATION	59.00
60.00	06000	LABORATORY	60.00
60.01	06001	BLOOD LABORATORY	60.01
63.00	06300	BLOOD STORING PROCESSING & TRANS.	63.00
65.00	06500	RESPIRATORY THERAPY	65.00
65.01	06501	SLEEP LAB	65.01
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
74.00	07400	RENAL DIALYSIS	74.00
OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	89.00
90.00	09000	CLINIC	90.00
90.01	09001	HOMER GLEN LAB	90.01
90.02	09002	HOMER GLEN FEC	90.02
90.03	09003	WOMENS HEALTH	90.03
91.00	09100	EMERGENCY	91.00
91.01	09101	OP MENTAL HEALTH	91.01
91.02	09102	DIABETES CENTER	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
OTHER REIMBURSABLE COST CENTERS			
94.00	09400	HOME PROGRAM DIALYSIS	94.00
99.00	09900	CMHC	99.00
99.10	09910	CORF	99.10
101.00	10100	HOME HEALTH AGENCY	101.00
SPECIAL PURPOSE COST CENTERS			
109.00	10900	PANCREAS ACQUISITION	109.00
110.00	11000	INTESTINAL ACQUISITION	110.00
111.00	11100	ISLET ACQUISITION	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
		8,559	

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0213

Period:
From 10/01/2020
To 09/30/2021

Worksheet B-1

Date/Time Prepared:
2/28/2022 12:24 pm

Cost Center Description		PARAMED ED PRGM (ASSIGNED TIME)	
		23.00	
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT FLOWER COFFEE SHOP & CANTEEN	0
192.00	19200	PHYSICIANS PRIVATE OFFICES	0
192.01	19201	FOUNDATION	0
200.00		Cross Foot Adjustments	
201.00		Negative Cost Centers	
202.00		Cost to be allocated (per Wkst. B, Part I)	805,475
203.00		Unit cost multiplier (Wkst. B, Part I)	94.108541
204.00		Cost to be allocated (per Wkst. B, Part II)	62,765
205.00		Unit cost multiplier (Wkst. B, Part II)	7.333216
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)	0
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)	0.000000

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0213

Period:
From 10/01/2020
To 09/30/2021Worksheet C
Part I
Date/Time Prepared:
2/28/2022 12:24 pm

			Title XVIII		Hospital		PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	
					Total Costs	RCE Disallowance		
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	82,317,476		82,317,476	71,373	82,388,849	30.00
31.00	03100	INTENSIVE CARE UNIT	18,203,411		18,203,411	18,363	18,221,774	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	0		0	0	0	33.00
40.00	04000	SUBPROVIDER - IPF	0		0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	11,074,800		11,074,800	0	11,074,800	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	42.00
43.00	04300	NURSERY	13,532,028		13,532,028	0	13,532,028	43.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
45.00	04500	NURSING FACILITY	0		0	0	0	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	41,277,360		41,277,360	46,128	41,323,488	50.00
51.00	05100	RECOVERY ROOM	3,010,997		3,010,997	0	3,010,997	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,121,603		6,121,603	0	6,121,603	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	25,610,343		25,610,343	84,923	25,695,266	54.00
54.01	05401	ULTRASOUND	2,784,841		2,784,841	0	2,784,841	54.01
57.00	05700	CT SCAN	4,023,275		4,023,275	0	4,023,275	57.00
58.00	05800	MRI	2,172,849		2,172,849	0	2,172,849	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	15,522,560		15,522,560	61,315	15,583,875	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
63.00	06300	BLOOD STORING PROCESSING & TRANS.	2,776,804		2,776,804	0	2,776,804	63.00
65.00	06500	RESPIRATORY THERAPY	4,750,395	0	4,750,395	3,235	4,753,630	65.00
65.01	06501	SLEEP LAB	607,425	0	607,425	0	607,425	65.01
66.00	06600	PHYSICAL THERAPY	3,709,064	0	3,709,064	0	3,709,064	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,722,755	0	3,722,755	0	3,722,755	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	3,631,798		3,631,798	15,976	3,647,774	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	587,486		587,486	0	587,486	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	53,709,579		53,709,579	0	53,709,579	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	28,774,335		28,774,335	0	28,774,335	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	37,364,760		37,364,760	0	37,364,760	73.00
74.00	07400	RENAL DIALYSIS	1,262,857		1,262,857	17,641	1,280,498	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000	CLINIC	1,630,285		1,630,285	9,288	1,639,573	90.00
90.01	09001	HOMER GLEN LAB	0		0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0		0	0	0	90.02
90.03	09003	WOMENS HEALTH	0		0	0	0	90.03
91.00	09100	EMERGENCY	23,190,035		23,190,035	29,276	23,219,311	91.00
91.01	09101	OP MENTAL HEALTH	0		0	0	0	91.01
91.02	09102	DIABETES CENTER	532,755		532,755	0	532,755	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	11,899,297		11,899,297	0	11,899,297	92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0		0	0	0	94.00
99.00	09900	CMHC	0		0	0	0	99.00
99.10	09910	CORF	0		0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	6,147,023		6,147,023	0	6,147,023	101.00
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0		0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0		0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0		0	0	0	111.00
200.00		Subtotal (see instructions)	409,948,196	0	409,948,196	357,518	410,305,714	200.00
201.00		Less Observation Beds	11,899,297		11,899,297	0	11,899,297	201.00
202.00		Total (see instructions)	398,048,899	0	398,048,899	357,518	398,406,417	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0213

Period:
From 10/01/2020
To 09/30/2021Worksheet C
Part I
Date/Time Prepared:
2/28/2022 12:24 pm

			Title XVIII			Hospital	PPS
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	91,428,610		91,428,610		30.00
31.00	03100	INTENSIVE CARE UNIT	25,449,755		25,449,755		31.00
33.00	03300	BURN INTENSIVE CARE UNIT	0		0		33.00
40.00	04000	SUBPROVIDER - IPF	0		0		40.00
41.00	04100	SUBPROVIDER - IRF	24,597,508		24,597,508		41.00
42.00	04200	SUBPROVIDER	0		0		42.00
43.00	04300	NURSERY	11,240,057		11,240,057		43.00
44.00	04400	SKILLED NURSING FACILITY	0		0		44.00
45.00	04500	NURSING FACILITY	0		0		45.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	48,414,233	85,666,028	134,080,261	0.307856	0.000000
51.00	05100	RECOVERY ROOM	15,040,629	17,134,805	32,175,434	0.093581	0.000000
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,946,199	1,093,004	10,039,203	0.609770	0.000000
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	52,067,843	146,369,655	198,437,498	0.129060	0.000000
54.01	05401	ULTRASOUND	10,020,704	23,566,703	33,587,407	0.082913	0.000000
57.00	05700	CT SCAN	33,562,520	80,418,476	113,980,996	0.035298	0.000000
58.00	05800	MRI	10,390,229	22,477,780	32,868,009	0.066108	0.000000
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000
60.00	06000	LABORATORY	76,034,880	113,175,259	189,210,139	0.082039	0.000000
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000
63.00	06300	BLOOD STORING PROCESSING & TRANS.	11,403,456	3,736,572	15,140,028	0.183408	0.000000
65.00	06500	RESPIRATORY THERAPY	13,131,298	2,336,728	15,468,026	0.307111	0.000000
65.01	06501	SLEEP LAB	0	3,963,345	3,963,345	0.153261	0.000000
66.00	06600	PHYSICAL THERAPY	14,999,133	1,846,708	16,845,841	0.220177	0.000000
67.00	06700	OCCUPATIONAL THERAPY	5,457	15,103,543	15,109,000	0.246393	0.000000
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000
69.00	06900	ELECTROCARDIOLOGY	14,594,389	12,651,038	27,245,427	0.133299	0.000000
70.00	07000	ELECTROENCEPHALOGRAPHY	1,565,925	3,696,913	5,262,838	0.111629	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	40,808,427	43,790,297	84,598,724	0.634875	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	28,918,010	25,341,618	54,259,628	0.530308	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	72,842,908	30,661,666	103,504,574	0.360996	0.000000
74.00	07400	RENAL DIALYSIS	4,372,529	377,154	4,749,683	0.265882	0.000000
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	09000	CLINIC	0	6,028,580	6,028,580	0.270426	0.000000
90.01	09001	HOMER GLEN LAB	0	0	0	0.000000	0.000000
90.02	09002	HOMER GLEN FEC	0	0	0	0.000000	0.000000
90.03	09003	WOMENS HEALTH	0	0	0	0.000000	0.000000
91.00	09100	EMERGENCY	43,204,058	105,993,123	149,197,181	0.155432	0.000000
91.01	09101	OP MENTAL HEALTH	0	0	0	0.000000	0.000000
91.02	09102	DIABETES CENTER	338,193	730,546	1,068,739	0.498489	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	5,002,429	23,541,899	28,544,328	0.416871	0.000000
	OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0.000000	0.000000
99.00	09900	CMHC	0	0	0		99.00
99.10	09910	CORF	0	0	0		99.10
101.00	10100	HOME HEALTH AGENCY	0	5,608,499	5,608,499		101.00
	SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0		109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0		110.00
111.00	11100	ISLET ACQUISITION	0	0	0		111.00
200.00		Subtotal (see instructions)	658,379,379	775,309,939	1,433,689,318		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	658,379,379	775,309,939	1,433,689,318		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0213

Period:
From 10/01/2020
To 09/30/2021Worksheet C
Part I
Date/Time Prepared:
2/28/2022 12:24 pm

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
33.00	03300	BURN INTENSIVE CARE UNIT			33.00
40.00	04000	SUBPROVIDER - IPF			40.00
41.00	04100	SUBPROVIDER - IRF			41.00
42.00	04200	SUBPROVIDER			42.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
45.00	04500	NURSING FACILITY			45.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.308200		50.00
51.00	05100	RECOVERY ROOM	0.093581		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.609770		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.129488		54.00
54.01	05401	ULTRASOUND	0.082913		54.01
57.00	05700	CT SCAN	0.035298		57.00
58.00	05800	MRI	0.066108		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.082363		60.00
60.01	06001	BLOOD LABORATORY	0.000000		60.01
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0.183408		63.00
65.00	06500	RESPIRATORY THERAPY	0.307320		65.00
65.01	06501	SLEEP LAB	0.153261		65.01
66.00	06600	PHYSICAL THERAPY	0.220177		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.246393		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.133886		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.111629		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.634875		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.530308		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.360996		73.00
74.00	07400	RENAL DIALYSIS	0.269597		74.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC			88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER			89.00
90.00	09000	CLINIC	0.271967		90.00
90.01	09001	HOMER GLEN LAB	0.000000		90.01
90.02	09002	HOMER GLEN FEC	0.000000		90.02
90.03	09003	WOMENS HEALTH	0.000000		90.03
91.00	09100	EMERGENCY	0.155628		91.00
91.01	09101	OP MENTAL HEALTH	0.000000		91.01
91.02	09102	DIABETES CENTER	0.498489		91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.416871		92.00
OTHER REIMBURSABLE COST CENTERS					
94.00	09400	HOME PROGRAM DIALYSIS	0.000000		94.00
99.00	09900	CMHC			99.00
99.10	09910	CORF			99.10
101.00	10100	HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS					
109.00	10900	PANCREAS ACQUISITION			109.00
110.00	11000	INTESTINAL ACQUISITION			110.00
111.00	11100	ISLET ACQUISITION			111.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0213

Period:
From 10/01/2020
To 09/30/2021Worksheet C
Part I
Date/Time Prepared:
2/28/2022 12:24 pm

				Title XIX		Hospital		PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
					Total Costs	RCE Disallowance	Total Costs		
			1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	82,317,476		82,317,476	71,373	82,388,849	30.00	
31.00	03100	INTENSIVE CARE UNIT	18,203,411		18,203,411	18,363	18,221,774	31.00	
33.00	03300	BURN INTENSIVE CARE UNIT	0		0	0	0	33.00	
40.00	04000	SUBPROVIDER - IPF	0		0	0	0	40.00	
41.00	04100	SUBPROVIDER - IRF	11,074,800		11,074,800	0	11,074,800	41.00	
42.00	04200	SUBPROVIDER	0		0	0	0	42.00	
43.00	04300	NURSERY	13,532,028		13,532,028	0	13,532,028	43.00	
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00	
45.00	04500	NURSING FACILITY	0		0	0	0	45.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	41,277,360		41,277,360	46,128	41,323,488	50.00	
51.00	05100	RECOVERY ROOM	3,010,997		3,010,997	0	3,010,997	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,121,603		6,121,603	0	6,121,603	52.00	
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	25,610,343		25,610,343	84,923	25,695,266	54.00	
54.01	05401	ULTRASOUND	2,784,841		2,784,841	0	2,784,841	54.01	
57.00	05700	CT SCAN	4,023,275		4,023,275	0	4,023,275	57.00	
58.00	05800	MRI	2,172,849		2,172,849	0	2,172,849	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00	
60.00	06000	LABORATORY	15,522,560		15,522,560	61,315	15,583,875	60.00	
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01	
63.00	06300	BLOOD STORING PROCESSING & TRANS.	2,776,804		2,776,804	0	2,776,804	63.00	
65.00	06500	RESPIRATORY THERAPY	4,750,395	0	4,750,395	3,235	4,753,630	65.00	
65.01	06501	SLEEP LAB	607,425	0	607,425	0	607,425	65.01	
66.00	06600	PHYSICAL THERAPY	3,709,064	0	3,709,064	0	3,709,064	66.00	
67.00	06700	OCCUPATIONAL THERAPY	3,722,755	0	3,722,755	0	3,722,755	67.00	
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	3,631,798		3,631,798	15,976	3,647,774	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	587,486		587,486	0	587,486	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	53,709,579		53,709,579	0	53,709,579	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	28,774,335		28,774,335	0	28,774,335	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	37,364,760		37,364,760	0	37,364,760	73.00	
74.00	07400	RENAL DIALYSIS	1,262,857		1,262,857	17,641	1,280,498	74.00	
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	88.00	
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00	
90.00	09000	CLINIC	1,630,285		1,630,285	9,288	1,639,573	90.00	
90.01	09001	HOMER GLEN LAB	0		0	0	0	90.01	
90.02	09002	HOMER GLEN FEC	0		0	0	0	90.02	
90.03	09003	WOMENS HEALTH	0		0	0	0	90.03	
91.00	09100	EMERGENCY	23,190,035		23,190,035	29,276	23,219,311	91.00	
91.01	09101	OP MENTAL HEALTH	0		0	0	0	91.01	
91.02	09102	DIABETES CENTER	532,755		532,755	0	532,755	91.02	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	11,899,297		11,899,297	0	11,899,297	92.00	
OTHER REIMBURSABLE COST CENTERS									
94.00	09400	HOME PROGRAM DIALYSIS	0		0	0	0	94.00	
99.00	09900	CMHC	0		0	0	0	99.00	
99.10	09910	CORF	0		0	0	0	99.10	
101.00	10100	HOME HEALTH AGENCY	6,147,023		6,147,023	0	6,147,023	101.00	
SPECIAL PURPOSE COST CENTERS									
109.00	10900	PANCREAS ACQUISITION	0		0	0	0	109.00	
110.00	11000	INTESTINAL ACQUISITION	0		0	0	0	110.00	
111.00	11100	ISLET ACQUISITION	0		0	0	0	111.00	
200.00		Subtotal (see instructions)	409,948,196	0	409,948,196	357,518	410,305,714	200.00	
201.00		Less Observation Beds	11,899,297		11,899,297	0	11,899,297	201.00	
202.00		Total (see instructions)	398,048,899	0	398,048,899	357,518	398,406,417	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0213

Period:
From 10/01/2020
To 09/30/2021Worksheet C
Part I
Date/Time Prepared:
2/28/2022 12:24 pm

			Title XIX		Hospital	PPS		
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	91,428,610		91,428,610			30.00
31.00	03100	INTENSIVE CARE UNIT	25,449,755		25,449,755			31.00
33.00	03300	BURN INTENSIVE CARE UNIT	0		0			33.00
40.00	04000	SUBPROVIDER - IPF	0		0			40.00
41.00	04100	SUBPROVIDER - IRF	24,597,508		24,597,508			41.00
42.00	04200	SUBPROVIDER	0		0			42.00
43.00	04300	NURSERY	11,240,057		11,240,057			43.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
45.00	04500	NURSING FACILITY	0		0			45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	48,414,233	85,666,028	134,080,261	0.307856	0.000000	50.00
51.00	05100	RECOVERY ROOM	15,040,629	17,134,805	32,175,434	0.093581	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,946,199	1,093,004	10,039,203	0.609770	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	52,067,843	146,369,655	198,437,498	0.129060	0.000000	54.00
54.01	05401	ULTRASOUND	10,020,704	23,566,703	33,587,407	0.082913	0.000000	54.01
57.00	05700	CT SCAN	33,562,520	80,418,476	113,980,996	0.035298	0.000000	57.00
58.00	05800	MRI	10,390,229	22,477,780	32,868,009	0.066108	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	76,034,880	113,175,259	189,210,139	0.082039	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
63.00	06300	BLOOD STORING PROCESSING & TRANS.	11,403,456	3,736,572	15,140,028	0.183408	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	13,131,298	2,336,728	15,468,026	0.307111	0.000000	65.00
65.01	06501	SLEEP LAB	0	3,963,345	3,963,345	0.153261	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	14,999,133	1,846,708	16,845,841	0.220177	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,457	15,103,543	15,109,000	0.246393	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	14,594,389	12,651,038	27,245,427	0.133299	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,565,925	3,696,913	5,262,838	0.111629	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	40,808,427	43,790,297	84,598,724	0.634875	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	28,918,010	25,341,618	54,259,628	0.530308	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	72,842,908	30,661,666	103,504,574	0.360996	0.000000	73.00
74.00	07400	RENAL DIALYSIS	4,372,529	377,154	4,749,683	0.265882	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0.000000	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	0.000000	89.00
90.00	09000	CLINIC	0	6,028,580	6,028,580	0.270426	0.000000	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0.000000	0.000000	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0.000000	0.000000	90.02
90.03	09003	WOMENS HEALTH	0	0	0	0.000000	0.000000	90.03
91.00	09100	EMERGENCY	43,204,058	105,993,123	149,197,181	0.155432	0.000000	91.00
91.01	09101	OP MENTAL HEALTH	0	0	0	0.000000	0.000000	91.01
91.02	09102	DIABETES CENTER	338,193	730,546	1,068,739	0.498489	0.000000	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	5,002,429	23,541,899	28,544,328	0.416871	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0.000000	0.000000	94.00
99.00	09900	CMHC	0	0	0			99.00
99.10	09910	CORF	0	0	0			99.10
101.00	10100	HOME HEALTH AGENCY	0	5,608,499	5,608,499			101.00
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0			109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0			110.00
111.00	11100	ISLET ACQUISITION	0	0	0			111.00
200.00		Subtotal (see instructions)	658,379,379	775,309,939	1,433,689,318			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	658,379,379	775,309,939	1,433,689,318			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0213	Period: From 10/01/2020 To 09/30/2021	Worksheet C Part I Date/Time Prepared: 2/28/2022 12:24 pm
Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital
			11.00		PPS
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
33.00	03300	BURN INTENSIVE CARE UNIT			33.00
40.00	04000	SUBPROVIDER - IPF			40.00
41.00	04100	SUBPROVIDER - IRF			41.00
42.00	04200	SUBPROVIDER			42.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
45.00	04500	NURSING FACILITY			45.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.308200		50.00
51.00	05100	RECOVERY ROOM	0.093581		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.609770		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.129488		54.00
54.01	05401	ULTRASOUND	0.082913		54.01
57.00	05700	CT SCAN	0.035298		57.00
58.00	05800	MRI	0.066108		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.082363		60.00
60.01	06001	BLOOD LABORATORY	0.000000		60.01
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0.183408		63.00
65.00	06500	RESPIRATORY THERAPY	0.307320		65.00
65.01	06501	SLEEP LAB	0.153261		65.01
66.00	06600	PHYSICAL THERAPY	0.220177		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.246393		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.133886		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.111629		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.634875		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.530308		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.360996		73.00
74.00	07400	RENAL DIALYSIS	0.269597		74.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
90.00	09000	CLINIC	0.271967		90.00
90.01	09001	HOMER GLEN LAB	0.000000		90.01
90.02	09002	HOMER GLEN FEC	0.000000		90.02
90.03	09003	WOMENS HEALTH	0.000000		90.03
91.00	09100	EMERGENCY	0.155628		91.00
91.01	09101	OP MENTAL HEALTH	0.000000		91.01
91.02	09102	DIABETES CENTER	0.498489		91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.416871		92.00
OTHER REIMBURSABLE COST CENTERS					
94.00	09400	HOME PROGRAM DIALYSIS	0.000000		94.00
99.00	09900	CMHC			99.00
99.10	09910	CORF			99.10
101.00	10100	HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS					
109.00	10900	PANCREAS ACQUISITION			109.00
110.00	11000	INTESTINAL ACQUISITION			110.00
111.00	11100	ISLET ACQUISITION			111.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

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

Provider CCN: 14-0213

Period:
From 10/01/2020
To 09/30/2021Worksheet C
Part II
Date/Time Prepared:
2/28/2022 12:24 pm

Cost Center Description			Title XIX		Hospital	PPS	
			Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount
			1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	41,277,360	5,954,888	35,322,472	0	0
51.00	05100	RECOVERY ROOM	3,010,997	205,993	2,805,004	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,121,603	304,938	5,816,665	0	0
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	25,610,343	2,630,401	22,979,942	0	0
54.01	05401	ULTRASOUND	2,784,841	201,011	2,583,830	0	0
57.00	05700	CT SCAN	4,023,275	530,242	3,493,033	0	0
58.00	05800	MRI	2,172,849	174,800	1,998,049	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	15,522,560	793,291	14,729,269	0	0
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
63.00	06300	BLOOD STORING PROCESSING & TRANS.	2,776,804	117,948	2,658,856	0	0
65.00	06500	RESPIRATORY THERAPY	4,750,395	261,633	4,488,762	0	0
65.01	06501	SLEEP LAB	607,425	24,265	583,160	0	0
66.00	06600	PHYSICAL THERAPY	3,709,064	143,608	3,565,456	0	0
67.00	06700	OCCUPATIONAL THERAPY	3,722,755	163,622	3,559,133	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	3,631,798	327,144	3,304,654	0	0
70.00	07000	ELECTROENCEPHALOGRAPHY	587,486	51,999	535,487	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	53,709,579	2,478,340	51,231,239	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	28,774,335	1,019,470	27,754,865	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	37,364,760	1,503,016	35,861,744	0	0
74.00	07400	RENAL DIALYSIS	1,262,857	118,405	1,144,452	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00	09000	CLINIC	1,630,285	59,120	1,571,165	0	0
90.01	09001	HOMER GLEN LAB	0	0	0	0	0
90.02	09002	HOMER GLEN FEC	0	0	0	0	0
90.03	09003	WOMENS HEALTH	0	0	0	0	0
91.00	09100	EMERGENCY	23,190,035	1,782,069	21,407,966	0	0
91.01	09101	OP MENTAL HEALTH	0	0	0	0	0
91.02	09102	DIABETES CENTER	532,755	20,111	512,644	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	11,899,297	1,000,350	10,898,947	0	0
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0
99.00	09900	CMHC	0	0	0	0	0
99.10	09910	CORF	0	0	0	0	0
101.00	10100	HOME HEALTH AGENCY	6,147,023	226,462	5,920,561	0	0
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0
111.00	11100	ISLET ACQUISITION	0	0	0	0	0
200.00		Subtotal (sum of lines 50 thru 199)	284,820,481	20,093,126	264,727,355	0	0
201.00		Less Observation Beds	11,899,297	1,000,350	10,898,947	0	0
202.00		Total (line 200 minus line 201)	272,921,184	19,092,776	253,828,408	0	0

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

Provider CCN: 14-0213

Period:
From 10/01/2020
To 09/30/2021Worksheet C
Part II
Date/Time Prepared:
2/28/2022 12:24 pm

Cost Center Description		Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	Hospital	PPS
		6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	41,277,360	134,080,261	0.307856		50.00
51.00	05100 RECOVERY ROOM	3,010,997	32,175,434	0.093581		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	6,121,603	10,039,203	0.609770		52.00
53.00	05300 ANESTHESIOLOGY	0	0	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	25,610,343	198,437,498	0.129060		54.00
54.01	05401 ULTRASOUND	2,784,841	33,587,407	0.082913		54.01
57.00	05700 CT SCAN	4,023,275	113,980,996	0.035298		57.00
58.00	05800 MRI	2,172,849	32,868,009	0.066108		58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000		59.00
60.00	06000 LABORATORY	15,522,560	189,210,139	0.082039		60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000		60.01
63.00	06300 BLOOD STORING PROCESSING & TRANS.	2,776,804	15,140,028	0.183408		63.00
65.00	06500 RESPIRATORY THERAPY	4,750,395	15,468,026	0.307111		65.00
65.01	06501 SLEEP LAB	607,425	3,963,345	0.153261		65.01
66.00	06600 PHYSICAL THERAPY	3,709,064	16,845,841	0.220177		66.00
67.00	06700 OCCUPATIONAL THERAPY	3,722,755	15,109,000	0.246393		67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0.000000		68.00
69.00	06900 ELECTROCARDIOLOGY	3,631,798	27,245,427	0.133299		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	587,486	5,262,838	0.111629		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	53,709,579	84,598,724	0.634875		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	28,774,335	54,259,628	0.530308		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	37,364,760	103,504,574	0.360996		73.00
74.00	07400 RENAL DIALYSIS	1,262,857	4,749,683	0.265882		74.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	0	0.000000		88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000		89.00
90.00	09000 CLINIC	1,630,285	6,028,580	0.270426		90.00
90.01	09001 HOMER GLEN LAB	0	0	0.000000		90.01
90.02	09002 HOMER GLEN FEC	0	0	0.000000		90.02
90.03	09003 WOMENS HEALTH	0	0	0.000000		90.03
91.00	09100 EMERGENCY	23,190,035	149,197,181	0.155432		91.00
91.01	09101 OP MENTAL HEALTH	0	0	0.000000		91.01
91.02	09102 DIABETES CENTER	532,755	1,068,739	0.498489		91.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	11,899,297	28,544,328	0.416871		92.00
OTHER REIMBURSABLE COST CENTERS						
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0.000000		94.00
99.00	09900 CMHC	0	0	0.000000		99.00
99.10	09910 CORF	0	0	0.000000		99.10
101.00	10100 HOME HEALTH AGENCY	6,147,023	5,608,499	1.096019		101.00
SPECIAL PURPOSE COST CENTERS						
109.00	10900 PANCREAS ACQUISITION	0	0	0.000000		109.00
110.00	11000 INTESTINAL ACQUISITION	0	0	0.000000		110.00
111.00	11100 ISLET ACQUISITION	0	0	0.000000		111.00
200.00	Subtotal (sum of lines 50 thru 199)	284,820,481	1,280,973,388			200.00
201.00	Less Observation Beds	11,899,297	0			201.00
202.00	Total (line 200 minus line 201)	272,921,184	1,280,973,388			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0213

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part I
Date/Time Prepared:
2/28/2022 12:24 pm

			Title XVIII		Hospital	PPS		
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)		
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	6,926,297	0	6,926,297	80,033	86.54	30.00	
31.00	INTENSIVE CARE UNIT	1,331,907		1,331,907	9,205	144.69	31.00	
33.00	BURN INTENSIVE CARE UNIT	0		0	0	0.00	33.00	
40.00	SUBPROVIDER - IPF	0	0	0	0	0.00	40.00	
41.00	SUBPROVIDER - IRF	959,537	0	959,537	8,492	112.99	41.00	
42.00	SUBPROVIDER	0	0	0	0	0.00	42.00	
43.00	NURSERY	1,552,750		1,552,750	7,612	203.99	43.00	
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00	
45.00	NURSING FACILITY	0		0	0	0.00	45.00	
200.00	Total (lines 30 through 199)	10,770,491		10,770,491	105,342		200.00	
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)					
		6.00	7.00					
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	26,947	2,331,993					30.00
31.00	INTENSIVE CARE UNIT	4,640	671,362					31.00
33.00	BURN INTENSIVE CARE UNIT	0	0					33.00
40.00	SUBPROVIDER - IPF	0	0					40.00
41.00	SUBPROVIDER - IRF	5,473	618,394					41.00
42.00	SUBPROVIDER	0	0					42.00
43.00	NURSERY	0	0					43.00
44.00	SKILLED NURSING FACILITY	0	0					44.00
45.00	NURSING FACILITY	0	0					45.00
200.00	Total (lines 30 through 199)	37,060	3,621,749					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0213

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part II
Date/Time Prepared:
2/28/2022 12:24 pm

				Title XVIII		Hospital	PPS	
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	5,954,888	134,080,261	0.044413	17,975,297	798,337	50.00
51.00	05100	RECOVERY ROOM	205,993	32,175,434	0.006402	3,657,670	23,416	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	304,938	10,039,203	0.030375	24,405	741	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,630,401	198,437,498	0.013256	22,410,279	297,071	54.00
54.01	05401	ULTRASOUND	201,011	33,587,407	0.005985	4,437,003	26,555	54.01
57.00	05700	CT SCAN	530,242	113,980,996	0.004652	15,548,967	72,334	57.00
58.00	05800	MRI	174,800	32,868,009	0.005318	4,430,828	23,563	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	793,291	189,210,139	0.004193	30,562,019	128,147	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00	06300	BLOOD STORING PROCESSING & TRANS.	117,948	15,140,028	0.007790	3,737,011	29,111	63.00
65.00	06500	RESPIRATORY THERAPY	261,633	15,468,026	0.016914	4,847,280	81,987	65.00
65.01	06501	SLEEP LAB	24,265	3,963,345	0.006122	0	0	65.01
66.00	06600	PHYSICAL THERAPY	143,608	16,845,841	0.008525	4,724,991	40,281	66.00
67.00	06700	OCCUPATIONAL THERAPY	163,622	15,109,000	0.010829	1,686	18	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	327,144	27,245,427	0.012007	6,973,514	83,731	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	51,999	5,262,838	0.009880	704,085	6,956	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,478,340	84,598,724	0.029295	13,893,153	407,000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,019,470	54,259,628	0.018789	11,312,999	212,560	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,503,016	103,504,574	0.014521	22,934,690	333,035	73.00
74.00	07400	RENAL DIALYSIS	118,405	4,749,683	0.024929	2,024,185	50,461	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	59,120	6,028,580	0.009807	0	0	90.00
90.01	09001	HOMER GLEN LAB	0	0	0.000000	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0.000000	0	0	90.02
90.03	09003	WOMENS HEALTH	0	0	0.000000	0	0	90.03
91.00	09100	EMERGENCY	1,782,069	149,197,181	0.011944	18,825,942	224,857	91.00
91.01	09101	OP MENTAL HEALTH	0	0	0.000000	0	0	91.01
91.02	09102	DIABETES CENTER	20,111	1,068,739	0.018818	58,563	1,102	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,000,350	28,544,328	0.035045	2,121,643	74,353	92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0.000000	0	0	94.00
200.00		Total (lines 50 through 199)	19,866,664	1,275,364,889		191,206,210	2,915,616	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0213		Period: From 10/01/2020 To 09/30/2021		Worksheet D Part III Date/Time Prepared: 2/28/2022 12:24 pm	
					Title XVIII		Hospital		PPS	
Cost Center Description			Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost			
			1A	1.00	2A	2.00	3.00			
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0	31.00	
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	0	33.00	
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	0	40.00	
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	0	41.00	
42.00	04200	SUBPROVIDER	0	0	0	0	0	0	42.00	
43.00	04300	NURSERY	0	0	0	0	0	0	43.00	
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	0	44.00	
45.00	04500	NURSING FACILITY	0	0	0	0	0	0	45.00	
200.00		Total (lines 30 through 199)	0	0	0	0	0	0	200.00	
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days			
			4.00	5.00	6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	80,033	0.00	26,947	0	30.00	
31.00	03100	INTENSIVE CARE UNIT		0	9,205	0.00	4,640	0	31.00	
33.00	03300	BURN INTENSIVE CARE UNIT		0	0	0.00	0	0	33.00	
40.00	04000	SUBPROVIDER - IPF	0	0	0	0.00	0	0	40.00	
41.00	04100	SUBPROVIDER - IRF	0	0	8,492	0.00	5,473	0	41.00	
42.00	04200	SUBPROVIDER	0	0	0	0.00	0	0	42.00	
43.00	04300	NURSERY		0	7,612	0.00	0	0	43.00	
44.00	04400	SKILLED NURSING FACILITY		0	0	0.00	0	0	44.00	
45.00	04500	NURSING FACILITY		0	0	0.00	0	0	45.00	
200.00		Total (lines 30 through 199)		0	105,342		37,060		200.00	
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)							
			9.00							
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0							30.00
31.00	03100	INTENSIVE CARE UNIT	0							31.00
33.00	03300	BURN INTENSIVE CARE UNIT	0							33.00
40.00	04000	SUBPROVIDER - IPF	0							40.00
41.00	04100	SUBPROVIDER - IRF	0							41.00
42.00	04200	SUBPROVIDER	0							42.00
43.00	04300	NURSERY	0							43.00
44.00	04400	SKILLED NURSING FACILITY	0							44.00
45.00	04500	NURSING FACILITY	0							45.00
200.00		Total (lines 30 through 199)	0							200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0213

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part IV
Date/Time Prepared:
2/28/2022 12:24 pm

Cost Center Description			Title XVIII		Hospital		PPS	
			Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	24,751	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
65.01	06501	SLEEP LAB	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	24,751	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	0	90.02
90.03	09003	WOMENS HEALTH	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	0	0	755,973	91.00
91.01	09101	OP MENTAL HEALTH	0	0	0	0	0	91.01
91.02	09102	DIABETES CENTER	0	0	0	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
200.00		Total (lines 50 through 199)	0	0	0	0	805,475	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0213		Period: From 10/01/2020 To 09/30/2021		Worksheet D Part IV Date/Time Prepared: 2/28/2022 12:24 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	134,080,261	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	32,175,434	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	24,751	24,751	10,039,203	0.002465	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	198,437,498	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	33,587,407	0.000000	54.01
57.00	05700	CT SCAN	0	0	0	113,980,996	0.000000	57.00
58.00	05800	MRI	0	0	0	32,868,009	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	189,210,139	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000	60.01
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0	0	0	15,140,028	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	15,468,026	0.000000	65.00
65.01	06501	SLEEP LAB	0	0	0	3,963,345	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	16,845,841	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	15,109,000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	24,751	24,751	27,245,427	0.000908	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	5,262,838	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	84,598,724	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	54,259,628	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	103,504,574	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	4,749,683	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000	89.00
90.00	09000	CLINIC	0	0	0	6,028,580	0.000000	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	0.000000	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	0.000000	90.02
90.03	09003	WOMENS HEALTH	0	0	0	0	0.000000	90.03
91.00	09100	EMERGENCY	0	755,973	755,973	149,197,181	0.005067	91.00
91.01	09101	OP MENTAL HEALTH	0	0	0	0	0.000000	91.01
91.02	09102	DIABETES CENTER	0	0	0	1,068,739	0.000000	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	28,544,328	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0.000000	94.00
200.00		Total (lines 50 through 199)	0	805,475	805,475	1,275,364,889		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0213

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part IV
Date/Time Prepared:
2/28/2022 12:24 pm

Cost Center Description		Title XVIII			Hospital		PPS	
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		9.00	10.00	11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	17,975,297	0	19,059,457	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	3,657,670	0	3,895,413	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.002465	24,405	60	916	2	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	22,410,279	0	58,076,876	0	54.00
54.01	05401	ULTRASOUND	0.000000	4,437,003	0	3,926,429	0	54.01
57.00	05700	CT SCAN	0.000000	15,548,967	0	22,355,335	0	57.00
58.00	05800	MRI	0.000000	4,430,828	0	5,688,494	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	30,562,019	0	10,969,277	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0.000000	3,737,011	0	609,142	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	4,847,280	0	612,565	0	65.00
65.01	06501	SLEEP LAB	0.000000	0	0	915,219	0	65.01
66.00	06600	PHYSICAL THERAPY	0.000000	4,724,991	0	29,940	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	1,686	0	242,589	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000908	6,973,514	6,332	3,629,481	3,296	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	704,085	0	930,203	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	13,893,153	0	12,233,783	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	11,312,999	0	8,474,466	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	22,934,690	0	10,881,203	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	2,024,185	0	119,427	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	89.00
90.00	09000	CLINIC	0.000000	0	0	3,121,247	0	90.00
90.01	09001	HOMER GLEN LAB	0.000000	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0.000000	0	0	0	0	90.02
90.03	09003	WOMENS HEALTH	0.000000	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.005067	18,825,942	95,391	15,977,739	80,959	91.00
91.01	09101	OP MENTAL HEALTH	0.000000	0	0	0	0	91.01
91.02	09102	DIABETES CENTER	0.000000	58,563	0	4,413	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	2,121,643	0	6,124,253	0	92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0.000000	0	0	0	0	94.00
200.00		Total (lines 50 through 199)		191,206,210	101,783	187,877,867	84,257	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0213

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part V
Date/Time Prepared:
2/28/2022 12:24 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	0.307856	19,059,457	46,602	0	5,867,568	50.00
51.00	05100	RECOVERY ROOM	0.093581	3,895,413	0	0	364,537	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.609770	916	0	0	559	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.129060	58,076,876	0	0	7,495,402	54.00
54.01	05401	ULTRASOUND	0.082913	3,926,429	0	0	325,552	54.01
57.00	05700	CT SCAN	0.035298	22,355,335	0	0	789,099	57.00
58.00	05800	MRI	0.066108	5,688,494	0	0	376,055	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.082039	10,969,277	23,646	0	899,909	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0.183408	609,142	0	0	111,722	63.00
65.00	06500	RESPIRATORY THERAPY	0.307111	612,565	0	0	188,125	65.00
65.01	06501	SLEEP LAB	0.153261	915,219	0	0	140,267	65.01
66.00	06600	PHYSICAL THERAPY	0.220177	29,940	0	0	6,592	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.246393	242,589	0	0	59,772	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.133299	3,629,481	0	0	483,806	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.111629	930,203	0	0	103,838	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.634875	12,233,783	0	0	7,766,923	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.530308	8,474,466	0	0	4,494,077	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.360996	10,881,203	0	15,096	3,928,071	73.00
74.00	07400	RENAL DIALYSIS	0.265882	119,427	0	0	31,753	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC						88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER						89.00
90.00	09000	CLINIC	0.270426	3,121,247	0	0	844,066	90.00
90.01	09001	HOMER GLEN LAB	0.000000	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0.000000	0	0	0	0	90.02
90.03	09003	WOMENS HEALTH	0.000000	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.155432	15,977,739	0	0	2,483,452	91.00
91.01	09101	OP MENTAL HEALTH	0.000000	0	0	0	0	91.01
91.02	09102	DIABETES CENTER	0.498489	4,413	0	0	2,200	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.416871	6,124,253	0	0	2,553,023	92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0.000000		0	0		94.00
200.00		Subtotal (see instructions)		187,877,867	70,248	15,096	39,316,368	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		187,877,867	70,248	15,096	39,316,368	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0213

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part V
Date/Time Prepared:
2/28/2022 12:24 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	14,347	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	05401	ULTRASOUND	0	0		54.01
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	1,940	0		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
65.01	06501	SLEEP LAB	0	0		65.01
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,450		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC				88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER				89.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	HOMER GLEN LAB	0	0		90.01
90.02	09002	HOMER GLEN FEC	0	0		90.02
90.03	09003	WOMENS HEALTH	0	0		90.03
91.00	09100	EMERGENCY	0	0		91.00
91.01	09101	OP MENTAL HEALTH	0	0		91.01
91.02	09102	DIABETES CENTER	0	0		91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0		94.00
200.00		Subtotal (see instructions)	16,287	5,450		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	16,287	5,450		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 14-0213 Component CCN: 14-T213	Period: From 10/01/2020 To 09/30/2021	Worksheet D Part II Date/Time Prepared: 2/28/2022 12:24 pm		
				Title XVIII	Subprovider - IRF	PPS		
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	5,954,888	134,080,261	0.044413	4,308	191	50.00
51.00	05100	RECOVERY ROOM	205,993	32,175,434	0.006402	18	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	304,938	10,039,203	0.030375	1	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,630,401	198,437,498	0.013256	150,459	1,994	54.00
54.01	05401	ULTRASOUND	201,011	33,587,407	0.005985	97,319	582	54.01
57.00	05700	CT SCAN	530,242	113,980,996	0.004652	149,990	698	57.00
58.00	05800	MRI	174,800	32,868,009	0.005318	83,686	445	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	793,291	189,210,139	0.004193	1,024,596	4,296	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00	06300	BLOOD STORING PROCESSING & TRANS.	117,948	15,140,028	0.007790	61,505	479	63.00
65.00	06500	RESPIRATORY THERAPY	261,633	15,468,026	0.016914	185,478	3,137	65.00
65.01	06501	SLEEP LAB	24,265	3,963,345	0.006122	0	0	65.01
66.00	06600	PHYSICAL THERAPY	143,608	16,845,841	0.008525	3,841,607	32,750	66.00
67.00	06700	OCCUPATIONAL THERAPY	163,622	15,109,000	0.010829	1,317	14	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	327,144	27,245,427	0.012007	39,327	472	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	51,999	5,262,838	0.009880	17,210	170	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,478,340	84,598,724	0.029295	234,861	6,880	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,019,470	54,259,628	0.018789	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,503,016	103,504,574	0.014521	1,207,553	17,535	73.00
74.00	07400	RENAL DIALYSIS	118,405	4,749,683	0.024929	250,645	6,248	74.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	59,120	6,028,580	0.009807	0	0	90.00
90.01	09001	HOMER GLEN LAB	0	0	0.000000	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0.000000	0	0	90.02
90.03	09003	WOMENS HEALTH	0	0	0.000000	0	0	90.03
91.00	09100	EMERGENCY	1,782,069	149,197,181	0.011944	116	1	91.00
91.01	09101	OP MENTAL HEALTH	0	0	0.000000	0	0	91.01
91.02	09102	DIABETES CENTER	20,111	1,068,739	0.018818	9,046	170	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	28,544,328	0.000000	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS							
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0.000000	0	0	94.00
200.00		Total (lines 50 through 199)	18,866,314	1,275,364,889		7,359,042	76,062	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0213 Component CCN: 14-T213		Period: From 10/01/2020 To 09/30/2021		Worksheet D Part IV Date/Time Prepared: 2/28/2022 12:24 pm	
				Title XVIII		Subprovider - IRF		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	24,751	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	0	54.01
57.00	05700	CT SCAN	0	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
65.01	06501	SLEEP LAB	0	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	24,751	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	0	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	0	0	90.02
90.03	09003	WOMENS HEALTH	0	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	0	0	0	755,973	91.00
91.01	09101	OP MENTAL HEALTH	0	0	0	0	0	0	91.01
91.02	09102	DIABETES CENTER	0	0	0	0	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS									
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	0	94.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	805,475	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0213 Component CCN: 14-T213		Period: From 10/01/2020 To 09/30/2021		Worksheet D Part IV Date/Time Prepared: 2/28/2022 12:24 pm	
				Title XVIII		Subprovider - IRF		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	134,080,261	0.000000	50.00
51.00	05100	RECOVERY ROOM		0	0	0	32,175,434	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	24,751	24,751	10,039,203	0.002465	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	198,437,498	0.000000	54.00
54.01	05401	ULTRASOUND		0	0	0	33,587,407	0.000000	54.01
57.00	05700	CT SCAN		0	0	0	113,980,996	0.000000	57.00
58.00	05800	MRI		0	0	0	32,868,009	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY		0	0	0	189,210,139	0.000000	60.00
60.01	06001	BLOOD LABORATORY		0	0	0	0	0.000000	60.01
63.00	06300	BLOOD STORING PROCESSING & TRANS.		0	0	0	15,140,028	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	15,468,026	0.000000	65.00
65.01	06501	SLEEP LAB		0	0	0	3,963,345	0.000000	65.01
66.00	06600	PHYSICAL THERAPY		0	0	0	16,845,841	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	15,109,000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY		0	24,751	24,751	27,245,427	0.000908	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	5,262,838	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	84,598,724	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	54,259,628	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	103,504,574	0.000000	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	4,749,683	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC		0	0	0	0	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	0	0.000000	89.00
90.00	09000	CLINIC		0	0	0	6,028,580	0.000000	90.00
90.01	09001	HOMER GLEN LAB		0	0	0	0	0.000000	90.01
90.02	09002	HOMER GLEN FEC		0	0	0	0	0.000000	90.02
90.03	09003	WOMENS HEALTH		0	0	0	0	0.000000	90.03
91.00	09100	EMERGENCY		0	755,973	755,973	149,197,181	0.005067	91.00
91.01	09101	OP MENTAL HEALTH		0	0	0	0	0.000000	91.01
91.02	09102	DIABETES CENTER		0	0	0	1,068,739	0.000000	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	28,544,328	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS									
94.00	09400	HOME PROGRAM DIALYSIS		0	0	0	0	0.000000	94.00
200.00		Total (lines 50 through 199)		0	805,475	805,475	1,275,364,889		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0213 Component CCN: 14-T213		Period: From 10/01/2020 To 09/30/2021		Worksheet D Part IV Date/Time Prepared: 2/28/2022 12:24 pm	
				Title XVIII		Subprovider - IRF		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	4,308	0	0	0	50.00
51.00	05100	RECOVERY ROOM		0.000000	18	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0.002465	1	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.000000	150,459	0	0	0	54.00
54.01	05401	ULTRASOUND		0.000000	97,319	0	0	0	54.01
57.00	05700	CT SCAN		0.000000	149,990	0	0	0	57.00
58.00	05800	MRI		0.000000	83,686	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY		0.000000	1,024,596	0	0	0	60.00
60.01	06001	BLOOD LABORATORY		0.000000	0	0	0	0	60.01
63.00	06300	BLOOD STORING PROCESSING & TRANS.		0.000000	61,505	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY		0.000000	185,478	0	0	0	65.00
65.01	06501	SLEEP LAB		0.000000	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY		0.000000	3,841,607	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0.000000	1,317	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0.000908	39,327	36	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0.000000	17,210	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.000000	234,861	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.000000	1,207,553	0	0	0	73.00
74.00	07400	RENAL DIALYSIS		0.000000	250,645	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC		0.000000	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER		0.000000	0	0	0	0	89.00
90.00	09000	CLINIC		0.000000	0	0	0	0	90.00
90.01	09001	HOMER GLEN LAB		0.000000	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC		0.000000	0	0	0	0	90.02
90.03	09003	WOMENS HEALTH		0.000000	0	0	0	0	90.03
91.00	09100	EMERGENCY		0.005067	116	1	0	0	91.00
91.01	09101	OP MENTAL HEALTH		0.000000	0	0	0	0	91.01
91.02	09102	DIABETES CENTER		0.000000	9,046	0	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0.000000	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS									
94.00	09400	HOME PROGRAM DIALYSIS		0.000000	0	0	0	0	94.00
200.00		Total (lines 50 through 199)			7,359,042	37	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0213

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part I
Date/Time Prepared:
2/28/2022 12:24 pm

			Title XIX		Hospital	PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	6,926,297	0	6,926,297	80,033	86.54	30.00
31.00	INTENSIVE CARE UNIT	1,331,907		1,331,907	9,205	144.69	31.00
33.00	BURN INTENSIVE CARE UNIT	0		0	0	0.00	33.00
40.00	SUBPROVIDER - IPF	0	0	0	0	0.00	40.00
41.00	SUBPROVIDER - IRF	959,537	0	959,537	8,492	112.99	41.00
42.00	SUBPROVIDER	0	0	0	0	0.00	42.00
43.00	NURSERY	1,552,750		1,552,750	7,612	203.99	43.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
45.00	NURSING FACILITY	0		0	0	0.00	45.00
200.00	Total (lines 30 through 199)	10,770,491		10,770,491	105,342		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	3,400	294,236				
31.00	INTENSIVE CARE UNIT	457	66,123				
33.00	BURN INTENSIVE CARE UNIT	0	0				
40.00	SUBPROVIDER - IPF	0	0				
41.00	SUBPROVIDER - IRF	128	14,463				
42.00	SUBPROVIDER	0	0				
43.00	NURSERY	378	77,108				
44.00	SKILLED NURSING FACILITY	0	0				
45.00	NURSING FACILITY	0	0				
200.00	Total (lines 30 through 199)	4,363	451,930				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0213

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part II
Date/Time Prepared:
2/28/2022 12:24 pm

Cost Center Description		Title XIX		Hospital		PPS	
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	5,954,888	134,080,261	0.044413	0	0 50.00
51.00	05100	RECOVERY ROOM	205,993	32,175,434	0.006402	0	0 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	304,938	10,039,203	0.030375	0	0 52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,630,401	198,437,498	0.013256	0	0 54.00
54.01	05401	ULTRASOUND	201,011	33,587,407	0.005985	0	0 54.01
57.00	05700	CT SCAN	530,242	113,980,996	0.004652	0	0 57.00
58.00	05800	MRI	174,800	32,868,009	0.005318	0	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0 59.00
60.00	06000	LABORATORY	793,291	189,210,139	0.004193	0	0 60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0 60.01
63.00	06300	BLOOD STORING PROCESSING & TRANS.	117,948	15,140,028	0.007790	0	0 63.00
65.00	06500	RESPIRATORY THERAPY	261,633	15,468,026	0.016914	0	0 65.00
65.01	06501	SLEEP LAB	24,265	3,963,345	0.006122	0	0 65.01
66.00	06600	PHYSICAL THERAPY	143,608	16,845,841	0.008525	0	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	163,622	15,109,000	0.010829	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	327,144	27,245,427	0.012007	0	0 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	51,999	5,262,838	0.009880	0	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,478,340	84,598,724	0.029295	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,019,470	54,259,628	0.018789	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,503,016	103,504,574	0.014521	0	0 73.00
74.00	07400	RENAL DIALYSIS	118,405	4,749,683	0.024929	0	0 74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0 88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0 89.00
90.00	09000	CLINIC	59,120	6,028,580	0.009807	0	0 90.00
90.01	09001	HOMER GLEN LAB	0	0	0.000000	0	0 90.01
90.02	09002	HOMER GLEN FEC	0	0	0.000000	0	0 90.02
90.03	09003	WOMENS HEALTH	0	0	0.000000	0	0 90.03
91.00	09100	EMERGENCY	1,782,069	149,197,181	0.011944	0	0 91.00
91.01	09101	OP MENTAL HEALTH	0	0	0.000000	0	0 91.01
91.02	09102	DIABETES CENTER	20,111	1,068,739	0.018818	0	0 91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,000,350	28,544,328	0.035045	0	0 92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0.000000	0	0 94.00
200.00		Total (lines 50 through 199)	19,866,664	1,275,364,889		0	0 200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0213		Period: From 10/01/2020 To 09/30/2021		Worksheet D Part III Date/Time Prepared: 2/28/2022 12:24 pm	
					Title XIX		Hospital		PPS	
Cost Center Description			Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost			
			1A	1.00	2A	2.00	3.00			
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0	31.00	
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	0	33.00	
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	0	40.00	
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	0	41.00	
42.00	04200	SUBPROVIDER	0	0	0	0	0	0	42.00	
43.00	04300	NURSERY	0	0	0	0	0	0	43.00	
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	0	44.00	
45.00	04500	NURSING FACILITY	0	0	0	0	0	0	45.00	
200.00		Total (lines 30 through 199)	0	0	0	0	0	0	200.00	
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days			
			4.00	5.00	6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	80,033	0.00	3,400	30.00		
31.00	03100	INTENSIVE CARE UNIT		0	9,205	0.00	457	31.00		
33.00	03300	BURN INTENSIVE CARE UNIT		0	0	0.00	0	33.00		
40.00	04000	SUBPROVIDER - IPF	0	0	0	0.00	0	40.00		
41.00	04100	SUBPROVIDER - IRF	0	0	8,492	0.00	128	41.00		
42.00	04200	SUBPROVIDER	0	0	0	0.00	0	42.00		
43.00	04300	NURSERY		0	7,612	0.00	378	43.00		
44.00	04400	SKILLED NURSING FACILITY		0	0	0.00	0	44.00		
45.00	04500	NURSING FACILITY		0	0	0.00	0	45.00		
200.00		Total (lines 30 through 199)		0	105,342		4,363	200.00		
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)							
			9.00							
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0						30.00	
31.00	03100	INTENSIVE CARE UNIT	0						31.00	
33.00	03300	BURN INTENSIVE CARE UNIT	0						33.00	
40.00	04000	SUBPROVIDER - IPF	0						40.00	
41.00	04100	SUBPROVIDER - IRF	0						41.00	
42.00	04200	SUBPROVIDER	0						42.00	
43.00	04300	NURSERY	0						43.00	
44.00	04400	SKILLED NURSING FACILITY	0						44.00	
45.00	04500	NURSING FACILITY	0						45.00	
200.00		Total (lines 30 through 199)	0						200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0213

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part IV
Date/Time Prepared:
2/28/2022 12:24 pm

Cost Center Description			Title XIX		Hospital		PPS	
			Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	24,751	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
65.01	06501	SLEEP LAB	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	24,751	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	0	90.02
90.03	09003	WOMENS HEALTH	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	0	0	755,973	91.00
91.01	09101	OP MENTAL HEALTH	0	0	0	0	0	91.01
91.02	09102	DIABETES CENTER	0	0	0	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
200.00		Total (lines 50 through 199)	0	0	0	0	805,475	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0213		Period: From 10/01/2020 To 09/30/2021		Worksheet D Part IV Date/Time Prepared: 2/28/2022 12:24 pm	
				Title XIX		Hospital		PPS	
Cost Center Description				All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
				4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	134,080,261	0.000000	50.00
51.00	05100	RECOVERY ROOM		0	0	0	32,175,434	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	24,751	24,751	10,039,203	0.002465	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	198,437,498	0.000000	54.00
54.01	05401	ULTRASOUND		0	0	0	33,587,407	0.000000	54.01
57.00	05700	CT SCAN		0	0	0	113,980,996	0.000000	57.00
58.00	05800	MRI		0	0	0	32,868,009	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY		0	0	0	189,210,139	0.000000	60.00
60.01	06001	BLOOD LABORATORY		0	0	0	0	0.000000	60.01
63.00	06300	BLOOD STORING PROCESSING & TRANS.		0	0	0	15,140,028	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	15,468,026	0.000000	65.00
65.01	06501	SLEEP LAB		0	0	0	3,963,345	0.000000	65.01
66.00	06600	PHYSICAL THERAPY		0	0	0	16,845,841	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	15,109,000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY		0	24,751	24,751	27,245,427	0.000908	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	5,262,838	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	84,598,724	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	54,259,628	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	103,504,574	0.000000	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	4,749,683	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC		0	0	0	0	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	0	0.000000	89.00
90.00	09000	CLINIC		0	0	0	6,028,580	0.000000	90.00
90.01	09001	HOMER GLEN LAB		0	0	0	0	0.000000	90.01
90.02	09002	HOMER GLEN FEC		0	0	0	0	0.000000	90.02
90.03	09003	WOMENS HEALTH		0	0	0	0	0.000000	90.03
91.00	09100	EMERGENCY		0	755,973	755,973	149,197,181	0.005067	91.00
91.01	09101	OP MENTAL HEALTH		0	0	0	0	0.000000	91.01
91.02	09102	DIABETES CENTER		0	0	0	1,068,739	0.000000	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	28,544,328	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS									
94.00	09400	HOME PROGRAM DIALYSIS		0	0	0	0	0.000000	94.00
200.00		Total (lines 50 through 199)		0	805,475	805,475	1,275,364,889		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0213

Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part IV
Date/Time Prepared:
2/28/2022 12:24 pm

Cost Center Description		Title XIX			Hospital		PPS	
		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		9.00	10.00	11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.002465	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	54.01
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
65.01	06501	SLEEP LAB	0.000000	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000908	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	89.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	HOMER GLEN LAB	0.000000	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0.000000	0	0	0	0	90.02
90.03	09003	WOMENS HEALTH	0.000000	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.005067	0	0	0	0	91.00
91.01	09101	OP MENTAL HEALTH	0.000000	0	0	0	0	91.01
91.02	09102	DIABETES CENTER	0.000000	0	0	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0.000000	0	0	0	0	94.00
200.00		Total (lines 50 through 199)		0	0	0	0	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0213

Period:

Worksheet D

Component CCN: 14-T213

From 10/01/2020
To 09/30/2021Part II
Date/Time Prepared:
2/28/2022 12:24 pm

			Title XIX		Subprovider - IRF	PPS	
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)
			1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	5,954,888	134,080,261	0.044413	0	0
51.00	05100	RECOVERY ROOM	205,993	32,175,434	0.006402	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	304,938	10,039,203	0.030375	0	0
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,630,401	198,437,498	0.013256	0	0
54.01	05401	ULTRASOUND	201,011	33,587,407	0.005985	0	0
57.00	05700	CT SCAN	530,242	113,980,996	0.004652	0	0
58.00	05800	MRI	174,800	32,868,009	0.005318	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0
60.00	06000	LABORATORY	793,291	189,210,139	0.004193	0	0
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0
63.00	06300	BLOOD STORING PROCESSING & TRANS.	117,948	15,140,028	0.007790	0	0
65.00	06500	RESPIRATORY THERAPY	261,633	15,468,026	0.016914	0	0
65.01	06501	SLEEP LAB	24,265	3,963,345	0.006122	0	0
66.00	06600	PHYSICAL THERAPY	143,608	16,845,841	0.008525	0	0
67.00	06700	OCCUPATIONAL THERAPY	163,622	15,109,000	0.010829	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0
69.00	06900	ELECTROCARDIOLOGY	327,144	27,245,427	0.012007	0	0
70.00	07000	ELECTROENCEPHALOGRAPHY	51,999	5,262,838	0.009880	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,478,340	84,598,724	0.029295	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,019,470	54,259,628	0.018789	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	1,503,016	103,504,574	0.014521	0	0
74.00	07400	RENAL DIALYSIS	118,405	4,749,683	0.024929	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0
90.00	09000	CLINIC	59,120	6,028,580	0.009807	0	0
90.01	09001	HOMER GLEN LAB	0	0	0.000000	0	0
90.02	09002	HOMER GLEN FEC	0	0	0.000000	0	0
90.03	09003	WOMENS HEALTH	0	0	0.000000	0	0
91.00	09100	EMERGENCY	1,782,069	149,197,181	0.011944	0	0
91.01	09101	OP MENTAL HEALTH	0	0	0.000000	0	0
91.02	09102	DIABETES CENTER	20,111	1,068,739	0.018818	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	28,544,328	0.000000	0	0
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0.000000	0	0
200.00		Total (lines 50 through 199)	18,866,314	1,275,364,889		0	0

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTSProvider CCN: 14-0213
Component CCN: 14-T213Period:
From 10/01/2020
To 09/30/2021Worksheet D
Part IV
Date/Time Prepared:
2/28/2022 12:24 pm

			Title XIX		Subprovider - IRF	PPS		
Cost Center Description			Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
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	24,751	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
65.01	06501	SLEEP LAB	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	24,751	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	0	90.02
90.03	09003	WOMENS HEALTH	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	0	0	755,973	91.00
91.01	09101	OP MENTAL HEALTH	0	0	0	0	0	91.01
91.02	09102	DIABETES CENTER	0	0	0	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
200.00		Total (lines 50 through 199)	0	0	0	0	805,475	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0213 Component CCN: 14-T213		Period: From 10/01/2020 To 09/30/2021		Worksheet D Part IV Date/Time Prepared: 2/28/2022 12:24 pm	
				Title XIX		Subprovider - IRF		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	134,080,261	0.000000	50.00
51.00	05100	RECOVERY ROOM		0	0	0	32,175,434	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	24,751	24,751	10,039,203	0.002465	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	198,437,498	0.000000	54.00
54.01	05401	ULTRASOUND		0	0	0	33,587,407	0.000000	54.01
57.00	05700	CT SCAN		0	0	0	113,980,996	0.000000	57.00
58.00	05800	MRI		0	0	0	32,868,009	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY		0	0	0	189,210,139	0.000000	60.00
60.01	06001	BLOOD LABORATORY		0	0	0	0	0.000000	60.01
63.00	06300	BLOOD STORING PROCESSING & TRANS.		0	0	0	15,140,028	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	15,468,026	0.000000	65.00
65.01	06501	SLEEP LAB		0	0	0	3,963,345	0.000000	65.01
66.00	06600	PHYSICAL THERAPY		0	0	0	16,845,841	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	15,109,000	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY		0	24,751	24,751	27,245,427	0.000908	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	5,262,838	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	84,598,724	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	54,259,628	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	103,504,574	0.000000	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	4,749,683	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC		0	0	0	0	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	0	0.000000	89.00
90.00	09000	CLINIC		0	0	0	6,028,580	0.000000	90.00
90.01	09001	HOMER GLEN LAB		0	0	0	0	0.000000	90.01
90.02	09002	HOMER GLEN FEC		0	0	0	0	0.000000	90.02
90.03	09003	WOMENS HEALTH		0	0	0	0	0.000000	90.03
91.00	09100	EMERGENCY		0	755,973	755,973	149,197,181	0.005067	91.00
91.01	09101	OP MENTAL HEALTH		0	0	0	0	0.000000	91.01
91.02	09102	DIABETES CENTER		0	0	0	1,068,739	0.000000	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	28,544,328	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS									
94.00	09400	HOME PROGRAM DIALYSIS		0	0	0	0	0.000000	94.00
200.00		Total (lines 50 through 199)		0	805,475	805,475	1,275,364,889		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0213 Component CCN: 14-T213		Period: From 10/01/2020 To 09/30/2021		Worksheet D Part IV Date/Time Prepared: 2/28/2022 12:24 pm	
				Title XIX		Subprovider - IRF		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	50.00
51.00	05100	RECOVERY ROOM		0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0.002465	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.000000	0	0	0	0	54.00
54.01	05401	ULTRASOUND		0.000000	0	0	0	0	54.01
57.00	05700	CT SCAN		0.000000	0	0	0	0	57.00
58.00	05800	MRI		0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY		0.000000	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY		0.000000	0	0	0	0	60.01
63.00	06300	BLOOD STORING PROCESSING & TRANS.		0.000000	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY		0.000000	0	0	0	0	65.00
65.01	06501	SLEEP LAB		0.000000	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY		0.000000	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0.000908	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.000000	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS		0.000000	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC		0.000000	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER		0.000000	0	0	0	0	89.00
90.00	09000	CLINIC		0.000000	0	0	0	0	90.00
90.01	09001	HOMER GLEN LAB		0.000000	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC		0.000000	0	0	0	0	90.02
90.03	09003	WOMENS HEALTH		0.000000	0	0	0	0	90.03
91.00	09100	EMERGENCY		0.005067	0	0	0	0	91.00
91.01	09101	OP MENTAL HEALTH		0.000000	0	0	0	0	91.01
91.02	09102	DIABETES CENTER		0.000000	0	0	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0.000000	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS									
94.00	09400	HOME PROGRAM DIALYSIS		0.000000	0	0	0	0	94.00
200.00		Total (lines 50 through 199)			0	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0213	Period: From 10/01/2020 To 09/30/2021	Worksheet D-1 Date/Time Prepared: 2/28/2022 12:24 pm
Cost Center Description		Title XVIII	Hospital	PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		80,033	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		80,033	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)		68,474	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		26,947	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)		82,388,849	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)		82,388,849	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)		82,388,849	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)		1,029.44	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		27,740,320	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)		27,740,320	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0213

Period:
From 10/01/2020
To 09/30/2021

Worksheet D-1

Date/Time Prepared:
2/28/2022 12:24 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	18,221,774	9,205	1,979.55	4,640	9,185,112	43.00	
44.00	CORONARY CARE UNIT						44.00	
45.00	BURN INTENSIVE CARE UNIT	0	0	0.00	0	0	45.00	
46.00	SURGICAL INTENSIVE CARE UNIT						46.00	
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00	
	Cost Center Description							
						1.00		
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						44,242,231	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						81,167,663	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)						3,003,355	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						3,017,399	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)						6,020,754	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						75,146,909	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)						11,559	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						1,029.44	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)						11,899,297	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0213

Period:
From 10/01/2020
To 09/30/2021

Worksheet D-1

Date/Time Prepared:
2/28/2022 12:24 pm

		Title XVIII		Hospital	PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	6,926,297	82,388,849	0.084068	11,899,297	1,000,350	90.00
91.00 Nursing Program cost	0	82,388,849	0.000000	11,899,297	0	91.00
92.00 Allied health cost	0	82,388,849	0.000000	11,899,297	0	92.00
93.00 All other Medical Education	0	82,388,849	0.000000	11,899,297	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0213 Component CCN: 14-T213	Period: From 10/01/2020 To 09/30/2021	Worksheet D-1 Date/Time Prepared: 2/28/2022 12:24 pm
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		8,492	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		8,492	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		8,492	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		5,473	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)		11,074,800	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)		11,074,800	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)		11,074,800	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)		1,304.15	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		7,137,613	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)		7,137,613	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0213 Component CCN: 14-T213	Period: From 10/01/2020 To 09/30/2021	Worksheet D-1 Date/Time Prepared: 2/28/2022 12:24 pm	
				Title XVIII	Subprovider - IRF	PPS	
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)	
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)			
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT	0	0	0.00	0	0	45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
							1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					1,702,853	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					8,840,466	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)					618,394	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					76,099	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					694,493	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					8,145,973	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0213 Component CCN: 14-T213		Period: From 10/01/2020 To 09/30/2021		Worksheet D-1 Date/Time Prepared: 2/28/2022 12:24 pm	
		Title XVIII		Subprovider - IRF		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	959,537	11,074,800	0.086641	0	0	90.00
91.00	Nursing Program cost	0	11,074,800	0.000000	0	0	91.00
92.00	Allied health cost	0	11,074,800	0.000000	0	0	92.00
93.00	All other Medical Education	0	11,074,800	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0213	Period: From 10/01/2020 To 09/30/2021	Worksheet D-1 Date/Time Prepared: 2/28/2022 12:24 pm
Cost Center Description		Title XIX	Hospital	PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		80,033	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		80,033	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)		68,474	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		3,400	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		7,612	15.00
16.00	Nursery days (title V or XIX only)		378	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)		82,388,849	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)		82,388,849	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)		82,388,849	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)		1,029.44	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		3,500,096	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		3,500,096	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0213

Period:
From 10/01/2020
To 09/30/2021

Worksheet D-1

Date/Time Prepared:
2/28/2022 12:24 pm

Cost Center Description			Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Hospital Program Days	PPS Program Cost (col. 3 x col. 4)	
			1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)		13,532,028	7,612	1,777.72	378	671,978	42.00
Intensive Care Type Inpatient Hospital Units								
43.00	INTENSIVE CARE UNIT		18,221,774	9,205	1,979.55	457	904,654	43.00
44.00	CORONARY CARE UNIT							44.00
45.00	BURN INTENSIVE CARE UNIT		0	0	0.00	0	0	45.00
46.00	SURGICAL INTENSIVE CARE UNIT							46.00
47.00	OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description								
								1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						5,076,728	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)						437,467	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)						437,467	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						4,639,261	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)						11,559	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						1,029.44	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)						11,899,297	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0213

Period:
From 10/01/2020
To 09/30/2021

Worksheet D-1

Date/Time Prepared:
2/28/2022 12:24 pm

Cost Center Description		Title XIX		Hospital	PPS	
		Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	6,926,297	82,388,849	0.084068	11,899,297	1,000,350 90.00
91.00	Nursing Program cost	0	82,388,849	0.000000	11,899,297	0 91.00
92.00	Allied health cost	0	82,388,849	0.000000	11,899,297	0 92.00
93.00	All other Medical Education	0	82,388,849	0.000000	11,899,297	0 93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0213 Component CCN: 14-T213	Period: From 10/01/2020 To 09/30/2021	Worksheet D-1 Date/Time Prepared: 2/28/2022 12:24 pm
		Title XIX	Subprovider - IRF	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		8,492	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		8,492	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		8,492	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)		128	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		7,612	15.00
16.00	Nursery days (title V or XIX only)		378	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)		11,074,800	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)		11,074,800	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)		11,074,800	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)		1,304.15	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		166,931	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)		166,931	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0213 Component CCN: 14-T213	Period: From 10/01/2020 To 09/30/2021	Worksheet D-1 Date/Time Prepared: 2/28/2022 12:24 pm	
				Title XIX	Subprovider - IRF	PPS	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT	0	0	0.00	0	0	45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					166,931	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)					14,463	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)					14,463	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					152,468	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0213 Component CCN: 14-T213		Period: From 10/01/2020 To 09/30/2021		Worksheet D-1 Date/Time Prepared: 2/28/2022 12:24 pm	
		Title XIX		Subprovider - IRF		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	959,537	11,074,800	0.086641	0	0	90.00
91.00	Nursing Program cost	0	11,074,800	0.000000	0	0	91.00
92.00	Allied health cost	0	11,074,800	0.000000	0	0	92.00
93.00	All other Medical Education	0	11,074,800	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0213	Period: From 10/01/2020 To 09/30/2021	Worksheet D-3 Date/Time Prepared: 2/28/2022 12:24 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		41,205,463	30.00
31.00	03100	INTENSIVE CARE UNIT		9,262,830	31.00
33.00	03300	BURN INTENSIVE CARE UNIT		0	33.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.308200	17,975,297	5,539,987 50.00
51.00	05100	RECOVERY ROOM	0.093581	3,657,670	342,288 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.609770	24,405	14,881 52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.129488	22,410,279	2,901,862 54.00
54.01	05401	ULTRASOUND	0.082913	4,437,003	367,885 54.01
57.00	05700	CT SCAN	0.035298	15,548,967	548,847 57.00
58.00	05800	MRI	0.066108	4,430,828	292,913 58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0 59.00
60.00	06000	LABORATORY	0.082363	30,562,019	2,517,180 60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0 60.01
63.00	06300	BLOOD STORING PROCESSING & TRANS.	0.183408	3,737,011	685,398 63.00
65.00	06500	RESPIRATORY THERAPY	0.307320	4,847,280	1,489,666 65.00
65.01	06501	SLEEP LAB	0.153261	0	0 65.01
66.00	06600	PHYSICAL THERAPY	0.220177	4,724,991	1,040,334 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.246393	1,686	415 67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	0.133886	6,973,514	933,656 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.111629	704,085	78,596 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.634875	13,893,153	8,820,416 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.530308	11,312,999	5,999,374 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.360996	22,934,690	8,279,331 73.00
74.00	07400	RENAL DIALYSIS	0.269597	2,024,185	545,714 74.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		0 88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0 89.00
90.00	09000	CLINIC	0.271967	0	0 90.00
90.01	09001	HOMER GLEN LAB	0.000000	0	0 90.01
90.02	09002	HOMER GLEN FEC	0.000000	0	0 90.02
90.03	09003	WOMENS HEALTH	0.000000	0	0 90.03
91.00	09100	EMERGENCY	0.155628	18,825,942	2,929,844 91.00
91.01	09101	OP MENTAL HEALTH	0.000000	0	0 91.01
91.02	09102	DIABETES CENTER	0.498489	58,563	29,193 91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.416871	2,121,643	884,451 92.00
OTHER REIMBURSABLE COST CENTERS					
94.00	09400	HOME PROGRAM DIALYSIS	0.000000	0	0 94.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		191,206,210	44,242,231 200.00
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)		191,206,210	44,242,231 202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0213 Component CCN: 14-T213	Period: From 10/01/2020 To 09/30/2021	Worksheet D-3 Date/Time Prepared: 2/28/2022 12:24 pm	
		Title XVIII	Subprovider - IRF	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
33.00	03300 BURN INTENSIVE CARE UNIT				33.00
40.00	04000 SUBPROVIDER - IPF				40.00
41.00	04100 SUBPROVIDER - IRF		11,693,650		41.00
42.00	04200 SUBPROVIDER				42.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.308200	4,308	1,328	50.00
51.00	05100 RECOVERY ROOM	0.093581	18	2	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.609770	1	1	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.129488	150,459	19,483	54.00
54.01	05401 ULTRASOUND	0.082913	97,319	8,069	54.01
57.00	05700 CT SCAN	0.035298	149,990	5,294	57.00
58.00	05800 MRI	0.066108	83,686	5,532	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000 LABORATORY	0.082363	1,024,596	84,389	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	60.01
63.00	06300 BLOOD STORING PROCESSING & TRANS.	0.183408	61,505	11,281	63.00
65.00	06500 RESPIRATORY THERAPY	0.307320	185,478	57,001	65.00
65.01	06501 SLEEP LAB	0.153261	0	0	65.01
66.00	06600 PHYSICAL THERAPY	0.220177	3,841,607	845,834	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.246393	1,317	324	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.133886	39,327	5,265	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.111629	17,210	1,921	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.634875	234,861	149,107	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.530308	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.360996	1,207,553	435,922	73.00
74.00	07400 RENAL DIALYSIS	0.269597	250,645	67,573	74.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000 CLINIC	0.271967	0	0	90.00
90.01	09001 HOMER GLEN LAB	0.000000	0	0	90.01
90.02	09002 HOMER GLEN FEC	0.000000	0	0	90.02
90.03	09003 WOMENS HEALTH	0.000000	0	0	90.03
91.00	09100 EMERGENCY	0.155628	116	18	91.00
91.01	09101 OP MENTAL HEALTH	0.000000	0	0	91.01
91.02	09102 DIABETES CENTER	0.498489	9,046	4,509	91.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.416871	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
94.00	09400 HOME PROGRAM DIALYSIS	0.000000	0	0	94.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		7,359,042	1,702,853	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)		7,359,042		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0213	Period: From 10/01/2020 To 09/30/2021	Worksheet E Part A Date/Time Prepared: 2/28/2022 12:24 pm	
		Title XVIII	Hospital	PPS	
				1.00	
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS					
1.00	DRG Amounts Other than Outlier Payments			0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)			0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)			70,356,774	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)			0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)			0	1.04
2.00	Outlier payments for discharges. (see instructions)				2.00
2.01	Outlier reconciliation amount			0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)			0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)			0	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)			453,385	2.04
3.00	Managed Care Simulated Payments			0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)			240.33	4.00
Indirect Medical Education Adjustment					
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)			0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)			0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)			0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.			0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).			0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.			0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)			0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)			0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records			0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.			0.00	11.00
12.00	Current year allowable FTE (see instructions)			0.00	12.00
13.00	Total allowable FTE count for the prior year.			0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.			0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.			0.00	15.00
16.00	Adjustment for residents in initial years of the program			0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure			0.00	17.00
18.00	Adjusted rolling average FTE count			0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).			0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)			0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)			0.000000	21.00
22.00	IME payment adjustment (see instructions)			0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)			0	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA					
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C) .			0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)			0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)			0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)			0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)			0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)			0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)			0	28.01
29.00	Total IME payment (sum of lines 22 and 28)			0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			0	29.01
Disproportionate Share Adjustment					
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)			2.11	30.00
31.00	Percentage of Medicaid patient days (see instructions)			14.67	31.00
32.00	Sum of lines 30 and 31			16.78	32.00
33.00	Allowable disproportionate share percentage (see instructions)			3.66	33.00
34.00	Disproportionate share adjustment (see instructions)			643,765	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0213	Period: From 10/01/2020 To 09/30/2021	Worksheet E Part A Date/Time Prepared: 2/28/2022 12:24 pm	
		Title XVIII	Hospital	PPS	
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
	Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)		0	0	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000		35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		0	2,527,884	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		0	2,527,884	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		2,527,884		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges (see instructions)		0		40.00
			Before 1/1	On/After 1/1	
			1.00	1.01	
41.00	Total ESRD Medicare discharges (see instructions)		0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges (see instructions)		0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00			42.00
43.00	Total Medicare ESRD inpatient days (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000			44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)		73,981,808		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)		73,981,808		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		5,642,912		50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0		51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0		52.00
53.00	Nursing and Allied Health Managed Care payment		50,635		53.00
54.00	Special add-on payments for new technologies		495,655		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)		101,783		58.00
59.00	Total (sum of amounts on lines 49 through 58)		80,272,793		59.00
60.00	Primary payer payments		13,145		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		80,259,648		61.00
62.00	Deductibles billed to program beneficiaries		7,075,208		62.00
63.00	Coinsurance billed to program beneficiaries		163,168		63.00
64.00	Allowable bad debts (see instructions)		832,703		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		541,257		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		401,676		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		73,562,529		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)		492,041		70.93
70.94	HRR adjustment amount (see instructions)		-28,340		70.94
70.95	Recovery of accelerated depreciation		0		70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0213	Period: From 10/01/2020 To 09/30/2021	Worksheet E Part A Date/Time Prepared: 2/28/2022 12:24 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)		74,026,230	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		73,826,132	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)		200,098	74.00
74.01	Balance due provider/program-PARHM (see instructions)		0	74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		2,590,136	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00
		Prior to 10/1	On/After 10/1	
		1.00	2.00	
HSP Bonus Payment Amount				
100.00	HSP bonus amount (see instructions)		0	100.00
HVBP Adjustment for HSP Bonus Payment				
101.00	HVBP adjustment factor (see instructions)		0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	102.00
HRR Adjustment for HSP Bonus Payment				
103.00	HRR adjustment factor (see instructions)		0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	104.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjustment				
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
Cost Reimbursement				
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)				
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
Adjustment to Medicare Part A Inpatient Reimbursement				
207.00	Program reimbursement under the \$410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
Comparison of PPS versus Cost Reimbursement				
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0213

Period:
From 10/01/2020
To 09/30/2021Worksheet E
Part A Exhibit 4
Date/Time Prepared:
2/28/2022 12:24 pm

		Title XVIII		Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)
		0	1.00	2.00	3.00	4.00	5.00
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	0	0	0	0
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	70,356,774	0	0	70,356,774	70,356,774
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0	0	0
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0	0	0	0
2.00	Outlier payments for discharges (see instructions)	2.00					
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	0	0	0	0	0
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	453,385	0	0	453,385	453,385
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0
4.00	Managed care simulated payments	3.00	0	0	0	0	0
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000	0
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000	0
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0366	0.0366	0.0366	0.0366	0
11.00	Disproportionate share adjustment (see instructions)	34.00	643,765	0	0	643,765	643,765
11.01	Uncompensated care payments	36.00	2,527,884	0	0	2,527,884	2,527,884
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	73,981,808	0	0	73,981,808	73,981,808
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	73,981,808	0	0	73,981,808	73,981,808
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	5,642,912	0	0	5,642,912	5,642,912

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0213

Period:
From 10/01/2020
To 09/30/2021Worksheet E
Part A Exhibit 4
Date/Time Prepared:
2/28/2022 12:24 pm

				Title XVIII		Hospital	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
17.00	Special add-on payments for new technologies	54.00	495,655	0	0	495,655	495,655	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	0	80,120,375	80,120,375	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	5,378,406	0	0	5,378,406	5,378,406	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	78,413	0	0	78,413	78,413	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0346	0.0346	0.0346	0.0346		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	186,093	0	0	186,093	186,093	25.00
26.00	Total prospective capital payments (see instructions)	12.00	5,642,912	0	0	5,642,912	5,642,912	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0213

Period:
From 10/01/2020
To 09/30/2021Worksheet E
Part A Exhibit 5
Date/Time Prepared:
2/28/2022 12:24 pm

		Title XVIII		Hospital		PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	0		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	70,356,774		70,356,774	70,356,774	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	0	0		0	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	453,385		453,385	453,385	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0366	0.0366	0.0366		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	643,765	0	643,765	643,765	11.00
11.01	Uncompensated care payments	36.00	2,527,884	0	2,527,884	2,527,884	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	73,981,808	0	73,981,808	73,981,808	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	73,981,808	0	73,981,808	73,981,808	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	5,642,912	0	5,642,912	5,642,912	16.00
17.00	Special add-on payments for new technologies	54.00	495,655	0	495,655	495,655	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			0	80,120,375	80,120,375	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0213

Period:
From 10/01/2020
To 09/30/2021Worksheet E
Part A Exhibit 5
Date/Time Prepared:
2/28/2022 12:24 pm

		Title XVIII		Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	5,378,406	0	5,378,406	5,378,406	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	78,413	0	78,413	78,413	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0346	0.0346	0.0346		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	186,093	0	186,093	186,093	25.00
26.00	Total prospective capital payments (see instructions)	12.00	5,642,912	0	5,642,912	5,642,912	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	492,041	0	492,041	492,041	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	-28,340	0	-28,340	-28,340	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: 14-0213	Period: From 10/01/2020 To 09/30/2021	Worksheet E Part B Date/Time Prepared: 2/28/2022 12:24 pm
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		21,737	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		39,232,111	2.00
3.00	OPPS payments		37,622,999	3.00
4.00	Outlier payment (see instructions)		15,529	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		84,257	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		21,737	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		85,344	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)		85,344	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)		85,344	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		63,607	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)		21,737	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)		37,722,785	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		9,320	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		6,513,523	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)		31,221,679	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)		31,221,679	30.00
31.00	Primary payer payments		8,060	31.00
32.00	Subtotal (line 30 minus line 31)		31,213,619	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)		449,119	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		291,927	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		257,782	36.00
37.00	Subtotal (see instructions)		31,505,546	37.00
38.00	MSP-LCC reconciliation amount from PS&R		100	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)		31,505,446	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		31,537,409	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)		-31,963	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		649,406	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0213 Component CCN: 14-T213	Period: From 10/01/2020 To 09/30/2021	Worksheet E Part B Date/Time Prepared: 2/28/2022 12:24 pm
		Title XVIII	Subprovider - IRF	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)		0	2.00
3.00	OPPS payments		0	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		0	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		0	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		0	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		0	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		0	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		0	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		0	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		0	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50	
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		0	40.00
40.01	Sequestration adjustment (see instructions)		0	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03	
41.00	Interim payments		0	41.00
41.01	Interim payments-PARHM		41.01	
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		42.01	
43.00	Balance due provider/program (see instructions)		0	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01	
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0213

Period:
From 10/01/2020
To 09/30/2021Worksheet E-1
Part I
Date/Time Prepared:
2/28/2022 12:24 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		74,014,670		31,594,646	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	06/09/2021	188,538	06/09/2021	57,237	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)		-188,538		-57,237	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)		73,826,132		31,537,409	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		200,098		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		31,963	6.02	
7.00	Total Medicare program liability (see instructions)		74,026,230		31,505,446	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

 Provider CCN: 14-0213
 Component CCN: 14-T213

 Period:
 From 10/01/2020
 To 09/30/2021

 Worksheet E-1
 Part I
 Date/Time Prepared:
 2/28/2022 12:24 pm

		Title XVIII		Subprovider - IRF		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		10,794,529		0	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		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)		10,794,529		0	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00	
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00	
6.01	SETTLEMENT TO PROVIDER		13,927		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		10,808,456		0	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor						

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 14-0213

Period:
From 10/01/2020
To 09/30/2021Worksheet E-1
Part II
Date/Time Prepared:
2/28/2022 12:24 pm

Title XVIII		Hospital	PPS
			1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS			
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION			
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14		1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6, sum of lines 1, 8 through 12, and 32.		2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2		3.00
4.00	Total inpatient days from S-3, Pt. I col. 8, sum of lines 1, 8 through 12, and 32.		4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200		5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20		6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168		7.00
8.00	Calculation of the HIT incentive payment (see instructions)		8.00
9.00	Sequestration adjustment amount (see instructions)		9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)		10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH			
30.00	Initial/interim HIT payment adjustment (see instructions)		30.00
31.00	Other Adjustment (specify)		31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)		32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0213 Component CCN: 14-T213	Period: From 10/01/2020 To 09/30/2021	Worksheet E-3 Part III Date/Time Prepared: 2/28/2022 12:24 pm
		Title XVIII	Subprovider - IRF	PPS
				1.00
PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)			10,546,359 1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0134 2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			142,376 3.00
4.00	Outlier Payments			189,092 4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)			0.00 5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 5.01
6.00	New Teaching program adjustment. (see instructions)			0.00 6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)			0.00 9.00
10.00	Average Daily Census (see instructions)			23.265753 10.00
11.00	Teaching Adjustment Factor (see instructions)			0.000000 11.00
12.00	Teaching Adjustment (see instructions)			0 12.00
13.00	Total PPS Payment (see instructions)			10,877,827 13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)			0 14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)			0 15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)			0 16.00
17.00	Subtotal (see instructions)			10,877,827 17.00
18.00	Primary payer payments			0 18.00
19.00	Subtotal (line 17 less line 18).			10,877,827 19.00
20.00	Deductibles			25,000 20.00
21.00	Subtotal (line 19 minus line 20)			10,852,827 21.00
22.00	Coinsurance			46,851 22.00
23.00	Subtotal (line 21 minus line 22)			10,805,976 23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			3,758 24.00
25.00	Adjusted reimbursable bad debts (see instructions)			2,443 25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 26.00
27.00	Subtotal (sum of lines 23 and 25)			10,808,419 27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0 28.00
29.00	Other pass through costs (see instructions)			37 29.00
30.00	Outlier payments reconciliation			0 30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 31.50
31.98	Recovery of accelerated depreciation.			0 31.98
31.99	Demonstration payment adjustment amount before sequestration			0 31.99
32.00	Total amount payable to the provider (see instructions)			10,808,456 32.00
32.01	Sequestration adjustment (see instructions)			0 32.01
32.02	Demonstration payment adjustment amount after sequestration			0 32.02
33.00	Interim payments			10,794,529 33.00
34.00	Tentative settlement (for contractor use only)			0 34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)			13,927 35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 36.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4			189,092 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0213	Period: From 10/01/2020 To 09/30/2021	Worksheet E-4 Date/Time Prepared: 2/28/2022 12:24 pm	
		Title XVIII	Hospital	PPS	
				1.00	
COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			0.00	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts)			0.00	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			0.00	6.00
7.00	Enter the lesser of line 5 or line 6			0.00	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	0.00	0.00	0.00	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	0.00	0.00	0.00	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00		10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		0.00		10.01
11.00	Total weighted FTE count	0.00	0.00		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	0.00		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	0.00		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	0.00	0.00		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00		15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00		16.01
17.00	Adjusted rolling average FTE count	0.00	0.00		17.00
18.00	Per resident amount	0.00	0.00		18.00
19.00	Approved amount for resident costs	0	0	0	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			0.00	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locality adjustment national average per resident amount (see instructions)			0.00	23.00
24.00	Multiply line 22 time line 23			0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			0	25.00
		Inpatient Part	Managed Care	Total	
		A			
		1.00	2.00	3.00	
COMPUTATION OF PROGRAM PATIENT LOAD					
26.00	Inpatient Days (see instructions) (Title XIX - see S-2 Part IX, line 3.02, column 2)	37,060	12,920		26.00
27.00	Total Inpatient Days (see instructions)	88,331	88,331		27.00
28.00	Ratio of inpatient days to total inpatient days	0.419558	0.146268		28.00
29.00	Program direct GME amount	0	0	0	29.00
29.01	Percent reduction for MA DGME				29.01
30.00	Reduction for direct GME payments for Medicare Advantage		0	0	30.00
31.00	Net Program direct GME amount			0	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0213	Period: From 10/01/2020 To 09/30/2021	Worksheet E-4 Date/Time Prepared: 2/28/2022 12:24 pm	
		Title XVIII	Hospital	PPS	
				1.00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING PROGRAM AND PARAMEDICAL EDUCATION COSTS)				
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)			0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)			4,749,683	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)			90,008,129	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)			13,145	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)			89,994,984	41.00
Part B Reasonable Cost					
42.00	Reasonable cost (see instructions)			39,338,105	42.00
43.00	Primary payer payments (see instructions)			8,060	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)			39,330,045	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)			129,325,029	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)			0.695882	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)			0.304118	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B					
48.00	Total program GME payment (line 31)			0	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)			0	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)			0	50.00

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

Provider CCN: 14-0213

Period:
From 10/01/2020
To 09/30/2021

Worksheet G

Date/Time Prepared:
2/28/2022 12:24 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	8,114,649	0	0	0	1.00
2.00 Temporary investments	2,218,765	0	0	0	2.00
3.00 Notes receivable	0	0	0	0	3.00
4.00 Accounts receivable	64,479,072	0	0	0	4.00
5.00 Other receivable	262,503	0	0	0	5.00
6.00 Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00 Inventory	10,342,039	0	0	0	7.00
8.00 Prepaid expenses	4,534,556	0	0	0	8.00
9.00 Other current assets	29	0	0	0	9.00
10.00 Due from other funds	68,523,436	0	0	0	10.00
11.00 Total current assets (sum of lines 1-10)	158,475,049	0	0	0	11.00
FIXED ASSETS					
12.00 Land	0	0	0	0	12.00
13.00 Land improvements	0	0	0	0	13.00
14.00 Accumulated depreciation	0	0	0	0	14.00
15.00 Buildings	645,789,453	0	0	0	15.00
16.00 Accumulated depreciation	-244,779,433	0	0	0	16.00
17.00 Leasehold improvements	0	0	0	0	17.00
18.00 Accumulated depreciation	0	0	0	0	18.00
19.00 Fixed equipment	0	0	0	0	19.00
20.00 Accumulated depreciation	0	0	0	0	20.00
21.00 Automobiles and trucks	0	0	0	0	21.00
22.00 Accumulated depreciation	0	0	0	0	22.00
23.00 Major movable equipment	0	0	0	0	23.00
24.00 Accumulated depreciation	0	0	0	0	24.00
25.00 Minor equipment depreciable	0	0	0	0	25.00
26.00 Accumulated depreciation	0	0	0	0	26.00
27.00 HIT designated Assets	0	0	0	0	27.00
28.00 Accumulated depreciation	0	0	0	0	28.00
29.00 Minor equipment-nondepreciable	0	0	0	0	29.00
30.00 Total fixed assets (sum of lines 12-29)	401,010,020	0	0	0	30.00
OTHER ASSETS					
31.00 Investments	0	0	0	0	31.00
32.00 Deposits on leases	0	0	0	0	32.00
33.00 Due from owners/officers	0	0	0	0	33.00
34.00 Other assets	478,295,532	0	0	0	34.00
35.00 Total other assets (sum of lines 31-34)	478,295,532	0	0	0	35.00
36.00 Total assets (sum of lines 11, 30, and 35)	1,037,780,601	0	0	0	36.00
CURRENT LIABILITIES					
37.00 Accounts payable	43,460,935	0	0	0	37.00
38.00 Salaries, wages, and fees payable	30,493,440	0	0	0	38.00
39.00 Payroll taxes payable	0	0	0	0	39.00
40.00 Notes and loans payable (short term)	8,695,000	0	0	0	40.00
41.00 Deferred income	0	0	0	0	41.00
42.00 Accelerated payments	77,333,748	0	0	0	42.00
43.00 Due to other funds	0	0	0	0	43.00
44.00 Other current liabilities	22,172,919	0	0	0	44.00
45.00 Total current liabilities (sum of lines 37 thru 44)	182,156,042	0	0	0	45.00
LONG TERM LIABILITIES					
46.00 Mortgage payable	357,386,697	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	21,448,236	0	0	0	49.00
50.00 Total long term liabilities (sum of lines 46 thru 49)	378,834,933	0	0	0	50.00
51.00 Total liabilities (sum of lines 45 and 50)	560,990,975	0	0	0	51.00
CAPITAL ACCOUNTS					
52.00 General fund balance	476,789,626	0	0	0	52.00
53.00 Specific purpose fund	0	0	0	0	53.00
54.00 Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00 Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00 Governing body created - endowment fund balance	0	0	0	0	56.00
57.00 Plant fund balance - invested in plant	0	0	0	0	57.00
58.00 Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00 Total fund balances (sum of lines 52 thru 58)	476,789,626	0	0	0	59.00
60.00 Total liabilities and fund balances (sum of lines 51 and 59)	1,037,780,601	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0213

Period:
From 10/01/2020
To 09/30/2021

Worksheet G-1

Date/Time Prepared:
2/28/2022 12:24 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		381,626,000		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		92,457,135				2.00
3.00	Total (sum of line 1 and line 2)		474,083,135		0		3.00
4.00	NET ASSETS RELEASED FROM RESTRICTION	2,888,000		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)		2,888,000		0		10.00
11.00	Subtotal (line 3 plus line 10)		476,971,135		0		11.00
12.00	NET ASSETS WITH DONOR RESTRICTIONS	181,000		0		0	12.00
13.00	ROUNDING	509		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)		181,509		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		476,789,626		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	NET ASSETS RELEASED FROM RESTRICTION		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	NET ASSETS WITH DONOR RESTRICTIONS		0				12.00
13.00	ROUNDING		0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-0213

Period:
From 10/01/2020
To 09/30/2021Worksheet G-2
Parts I & II
Date/Time Prepared:
2/28/2022 12:24 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	91,428,610		91,428,610	1.00
2.00	SUBPROVIDER - IPF	0		0	2.00
3.00	SUBPROVIDER - IRF	24,597,508		24,597,508	3.00
4.00	SUBPROVIDER	0		0	4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	0		0	7.00
8.00	NURSING FACILITY	0		0	8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	116,026,118		116,026,118	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	25,449,755		25,449,755	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT	0		0	13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	25,449,755		25,449,755	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	141,475,873		141,475,873	17.00
18.00	Ancillary services	457,118,768	633,407,292	1,090,526,060	18.00
19.00	Outpatient services	48,544,680	136,294,148	184,838,828	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		5,608,499	5,608,499	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC		0	0	24.00
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	NURSERY	11,240,057	0	11,240,057	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	658,379,378	775,309,939	1,433,689,317	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		444,580,661		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		444,580,661		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0213

Period:
From 10/01/2020
To 09/30/2021

Worksheet G-3

Date/Time Prepared:
2/28/2022 12:24 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	1,433,689,317	1.00
2.00	Less contractual allowances and discounts on patients' accounts	963,194,429	2.00
3.00	Net patient revenues (line 1 minus line 2)	470,494,888	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	444,580,661	4.00
5.00	Net income from service to patients (line 3 minus line 4)	25,914,227	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISC - OTHER REVENUE	10,437,258	24.00
24.01	NON-OPERATING INCOME	59,753,514	24.01
24.02	REVENUE RECLASS	1,166,977	24.02
24.03	ROUNDING	45	24.03
24.50	COVID-19 PHE Funding	7,000,000	24.50
25.00	Total other income (sum of lines 6-24)	78,357,794	25.00
26.00	Total (line 5 plus line 25)	104,272,021	26.00
27.00	BAD DEBTS	11,814,886	27.00
27.01	OTHER EXPENSES (SPECIFY)	0	27.01
27.02	OTHER EXPENSES (SPECIFY)	0	27.02
28.00	Total other expenses (sum of line 27 and subscripts)	11,814,886	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	92,457,135	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS					Provider CCN: 14-0213 HHA CCN: 14-7452	Period: From 10/01/2020 To 09/30/2021	Worksheet H Date/Time Prepared: 2/28/2022 12:24 pm
						Home Health Agency I	PPS
	Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Pur chased Services	Other Costs	Total (sum of cols. 1 thru 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures		0		0	0	1.00
2.00	Capital Related - Movable Equipment		0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	828,140	0	0	12,216	169	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	6,660	6,660	6.00
7.00	Physical Therapy	0	104,152	0	0	104,152	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	2,616,342	0	0	3,820	2,620,162	10.00
11.00	Home Health Aide	62,701	0	0	0	62,701	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	3,507,183	104,152	12,216	10,649	3,634,200	24.00
	Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
	7.00	8.00	9.00	10.00			
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0		1.00
2.00	Capital Related - Movable Equipment	0	0	0	0		2.00
3.00	Plant Operation & Maintenance	0	0	0	0		3.00
4.00	Transportation	0	0	0	0		4.00
5.00	Administrative and General	2,867	843,392	0	843,392		5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	6,660	0	6,660		6.00
7.00	Physical Therapy	0	104,152	0	104,152		7.00
8.00	Occupational Therapy	0	0	0	0		8.00
9.00	Speech Pathology	0	0	0	0		9.00
10.00	Medical Social Services	0	2,620,162	0	2,620,162		10.00
11.00	Home Health Aide	0	62,701	0	62,701		11.00
12.00	Supplies (see instructions)	0	0	0	0		12.00
13.00	Drugs	0	0	0	0		13.00
14.00	DME	0	0	0	0		14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0		15.00
16.00	Respiratory Therapy	0	0	0	0		16.00
17.00	Private Duty Nursing	0	0	0	0		17.00
18.00	Clinic	0	0	0	0		18.00
19.00	Health Promotion Activities	0	0	0	0		19.00
20.00	Day Care Program	0	0	0	0		20.00
21.00	Home Delivered Meals Program	0	0	0	0		21.00
22.00	Homemaker Service	0	0	0	0		22.00
23.00	All Others (specify)	0	0	0	0		23.00
23.50	Telemedicine	0	0	0	0		23.50
24.00	Total (sum of lines 1-23)	2,867	3,637,067	0	3,637,067		24.00

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

COST ALLOCATION - HHA GENERAL SERVICE COST

Provider CCN: 14-0213

Period:

Worksheet H-1

HHA CCN: 14-7452

From 10/01/2020
To 09/30/2021Part I
Date/Time Prepared:
2/28/2022 12:24 pmHome Health
Agency I

PPS

		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
			Bldgs & Fixtures	Movable Equipment				
			0	1.00	2.00	3.00	4.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	843,392	0	0	0	0	843,392	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	6,660	0	0	0	0	6,660	6.00
7.00	Physical Therapy	104,152	0	0	0	0	104,152	7.00
8.00	Occupational Therapy	0	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	2,620,162	0	0	0	0	2,620,162	10.00
11.00	Home Health Aide	62,701	0	0	0	0	62,701	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	3,637,067	0	0	0	0	3,637,067	24.00
		Administrative & General	Total (cols. 4A + 5)					
		5.00	6.00					
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures							1.00
2.00	Capital Related - Movable Equipment							2.00
3.00	Plant Operation & Maintenance							3.00
4.00	Transportation							4.00
5.00	Administrative and General	843,392						5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	2,011	8,671					6.00
7.00	Physical Therapy	31,443	135,595					7.00
8.00	Occupational Therapy	0	0					8.00
9.00	Speech Pathology	0	0					9.00
10.00	Medical Social Services	791,009	3,411,171					10.00
11.00	Home Health Aide	18,929	81,630					11.00
12.00	Supplies (see instructions)	0	0					12.00
13.00	Drugs	0	0					13.00
14.00	DME	0	0					14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0					15.00
16.00	Respiratory Therapy	0	0					16.00
17.00	Private Duty Nursing	0	0					17.00
18.00	Clinic	0	0					18.00
19.00	Health Promotion Activities	0	0					19.00
20.00	Day Care Program	0	0					20.00
21.00	Home Delivered Meals Program	0	0					21.00
22.00	Homemaker Service	0	0					22.00
23.00	All Others (specify)	0	0					23.00
23.50	Telemedicine	0	0					23.50
24.00	Total (sum of lines 1-23)		3,637,067					24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 14-0213

Period:

Worksheet H-1

HHA CCN: 14-7452

From 10/01/2020
To 09/30/2021Part II
Date/Time Prepared:
2/28/2022 12:24 pmHome Health
Agency I

PPS

	Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
	Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)					
	1.00	2.00	3.00	4.00	5A.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0			0		1.00
2.00	Capital Related - Movable Equipment		0		0		2.00
3.00	Plant Operation & Maintenance	0	0	0	0		3.00
4.00	Transportation (see instructions)	0	0	0	0		4.00
5.00	Administrative and General	0	0	0	0	-843,392	5.00
						2,793,675	
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	6,660	6.00
7.00	Physical Therapy	0	0	0	0	104,152	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	2,620,162	10.00
11.00	Home Health Aide	0	0	0	0	62,701	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	0	0	0	0	-843,392	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0	843,392	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000	0.301893	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0213

Period:

Worksheet H-2

HHA CCN: 14-7452

From 10/01/2020
To 09/30/2021Part I
Date/Time Prepared:
2/28/2022 12:24 pmHome Health
Agency I

PPS

Cost Center Description		HHA Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
			BLDG & FIXT	MVBLE EQUIP				
			0	1.00			2.00	
1.00	Administrative and General	0	0	868	900,185	901,053	259,564	1.00
2.00	Skilled Nursing Care	8,671	0	0	0	8,671	2,498	2.00
3.00	Physical Therapy	135,595	0	0	0	135,595	39,060	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	3,411,171	0	0	0	3,411,171	982,646	6.00
7.00	Home Health Aide	81,630	0	0	0	81,630	23,515	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	3,637,067	0	868	900,185	4,538,120	1,307,283	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000		21.00
Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		7.00	8.00	9.00	10.00	11.00	13.00	
1.00	Administrative and General	0	0	0	0	0	301,620	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	0	0	0	0	301,620	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0213

Period:

Worksheet H-2

HHA CCN: 14-7452

From 10/01/2020
To 09/30/2021Part I
Date/Time Prepared:
2/28/2022 12:24 pmHome Health
Agency I

PPS

Cost Center Description		CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	PARAMED ED PRGM	Subtotal	
		14.00	15.00	16.00	17.00	23.00	24.00	
1.00	Administrative and General	0	0	0	0	0	1,462,237	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	11,169	2.00
3.00	Physical Therapy	0	0	0	0	0	174,655	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	4,393,817	6.00
7.00	Home Health Aide	0	0	0	0	0	105,145	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	0	0	0	0	6,147,023	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00
Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs			
		25.00	26.00	27.00	28.00			
1.00	Administrative and General	0	1,462,237					1.00
2.00	Skilled Nursing Care	0	11,169	3,486	14,655			2.00
3.00	Physical Therapy	0	174,655	54,514	229,169			3.00
4.00	Occupational Therapy	0	0	0	0			4.00
5.00	Speech Pathology	0	0	0	0			5.00
6.00	Medical Social Services	0	4,393,817	1,371,419	5,765,236			6.00
7.00	Home Health Aide	0	105,145	32,818	137,963			7.00
8.00	Supplies (see instructions)	0	0	0	0			8.00
9.00	Drugs	0	0	0	0			9.00
10.00	DME	0	0	0	0			10.00
11.00	Home Dialysis Aide Services	0	0	0	0			11.00
12.00	Respiratory Therapy	0	0	0	0			12.00
13.00	Private Duty Nursing	0	0	0	0			13.00
14.00	Clinic	0	0	0	0			14.00
15.00	Health Promotion Activities	0	0	0	0			15.00
16.00	Day Care Program	0	0	0	0			16.00
17.00	Home Delivered Meals Program	0	0	0	0			17.00
18.00	Homemaker Service	0	0	0	0			18.00
19.00	All Others (specify)	0	0	0	0			19.00
19.50	Telemedicine	0	0	0	0			19.50
20.00	Total (sum of lines 1-19) (2)	0	6,147,023	1,462,237	6,147,023			20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.			0.312125				21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-0213

Period:

Worksheet H-2

HHA CCN: 14-7452

From 10/01/2020
To 09/30/2021Part II
Date/Time Prepared:
2/28/2022 12:24 pmHome Health
Agency I

PPS

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	Agency 1	OPERATION OF PLANT (SQUARE FEET)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)			ADMINISTRATIVE & GENERAL (ACCUM. COST)		
		1.00	2.00	4.00	5A	5.00	7.00	
1.00	Administrative and General	0	944	3,193,381	0	901,053	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	8,671	0	2.00
3.00	Physical Therapy	0	0	0	0	135,595	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	3,411,171	0	6.00
7.00	Home Health Aide	0	0	0	0	81,630	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	944	3,193,381		4,538,120	0	20.00
21.00	Total cost to be allocated	0	868	900,185		1,307,283	0	21.00
22.00	Unit cost multiplier	0.000000	0.919492	0.281891		0.288067	0.000000	22.00
Cost Center Description		LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRS ING)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
		8.00	9.00	10.00	11.00	13.00	14.00	
1.00	Administrative and General	0	0	0	0	73,029	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	0	0	0	73,029	0	20.00
21.00	Total cost to be allocated	0	0	0	0	301,620	0	21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.000000	0.000000	4.130140	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-0213

Period:

Worksheet H-2

HHA CCN: 14-7452

From 10/01/2020
To 09/30/2021Part II
Date/Time Prepared:
2/28/2022 12:24 pmHome Health
Agency I

PPS

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

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0213

Period:

Worksheet H-3

HHA CCN: 14-7452

From 10/01/2020
To 09/30/2021Part I
Date/Time Prepared:
2/28/2022 12:24 pm

				Title XVIII		Home Health Agency I	PPS	
Cost Center Description		From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	2.00	14,655		14,655	13,866	1.06	1.00
2.00	Physical Therapy	3.00	229,169	382,837	612,006	7,307	83.76	2.00
3.00	Occupational Therapy	4.00	0	173,052	173,052	3,545	48.82	3.00
4.00	Speech Pathology	5.00	0	0	0	182	0.00	4.00
5.00	Medical Social Services	6.00	5,765,236		5,765,236	70	82,360.51	5.00
6.00	Home Health Aide	7.00	137,963		137,963	1,696	81.35	6.00
7.00	Total (sum of lines 1-6)		6,147,023	555,889	6,702,912	26,666		7.00
				Program Visits				
				Part B				
				Not Subject to Deductibles & Coinsurance		Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
Limitation Cost Computation								
8.00	Skilled Nursing Care		16974	0	6,653			8.00
8.01	Skilled Nursing Care		16984	0	0			8.01
9.00	Physical Therapy		16974	0	3,874			9.00
9.01	Physical Therapy		16984	0	0			9.01
10.00	Occupational Therapy		16974	0	1,991			10.00
10.01	Occupational Therapy		16984	0	0			10.01
11.00	Speech Pathology		16974	0	81			11.00
11.01	Speech Pathology		16984	0	0			11.01
12.00	Medical Social Services		16974	0	43			12.00
12.01	Medical Social Services		16984	0	0			12.01
13.00	Home Health Aide		16974	0	947			13.00
13.01	Home Health Aide		16984	0	0			13.01
14.00	Total (sum of lines 8-13)			0	13,589			14.00
		From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
Supplies and Drugs Cost Computations								
15.00	Cost of Medical Supplies	8.00	0	18,500	18,500	29,140	0.634866	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00
				Program Visits		Cost of Services		
				Part B		Part B		
				Not Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance		
				Subject to Deductibles & Coinsurance		Subject to Deductibles & Coinsurance		
		6.00	7.00	8.00	9.00	10.00	11.00	
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	0	6,653		0	7,052		1.00
2.00	Physical Therapy	0	3,874		0	324,486		2.00
3.00	Occupational Therapy	0	1,991		0	97,201		3.00
4.00	Speech Pathology	0	81		0	0		4.00
5.00	Medical Social Services	0	43		0	3,541,502		5.00
6.00	Home Health Aide	0	947		0	77,038		6.00
7.00	Total (sum of lines 1-6)	0	13,589		0	4,047,279		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0213

Period:

Worksheet H-3

HHA CCN: 14-7452

From 10/01/2020
To 09/30/2021Part I
Date/Time Prepared:
2/28/2022 12:24 pm

Title XVIII

Home Health
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Cost Center Description						Agency 1			
		6.00	7.00	8.00	9.00	10.00	11.00		
Limitation Cost Computation									
8.00	Skilled Nursing Care							8.00	
8.01	Skilled Nursing Care							8.01	
9.00	Physical Therapy							9.00	
9.01	Physical Therapy							9.01	
10.00	Occupational Therapy							10.00	
10.01	Occupational Therapy							10.01	
11.00	Speech Pathology							11.00	
11.01	Speech Pathology							11.01	
12.00	Medical Social Services							12.00	
12.01	Medical Social Services							12.01	
13.00	Home Health Aide							13.00	
13.01	Home Health Aide							13.01	
14.00	Total (sum of lines 8-13)							14.00	
Cost Center Description		Program Covered Charges			Cost of Services				
		Part A	Part B		Part A	Part B			
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		
			6.00	7.00	8.00	9.00	10.00	11.00	
Supplies and Drugs Cost Computations									
15.00	Cost of Medical Supplies	0	0	0	0	0	0	15.00	
16.00	Cost of Drugs		0	0		0	0	16.00	
Cost Center Description		Total Program Cost (sum of cols. 9-10)							
		12.00							
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION									
Cost Per Visit Computation									
1.00	Skilled Nursing Care	7,052							1.00
2.00	Physical Therapy	324,486							2.00
3.00	Occupational Therapy	97,201							3.00
4.00	Speech Pathology	0							4.00
5.00	Medical Social Services	3,541,502							5.00
6.00	Home Health Aide	77,038							6.00
7.00	Total (sum of lines 1-6)	4,047,279							7.00
Cost Center Description									
		12.00							
Limitation Cost Computation									
8.00	Skilled Nursing Care								8.00
8.01	Skilled Nursing Care								8.01
9.00	Physical Therapy								9.00
9.01	Physical Therapy								9.01
10.00	Occupational Therapy								10.00
10.01	Occupational Therapy								10.01
11.00	Speech Pathology								11.00
11.01	Speech Pathology								11.01
12.00	Medical Social Services								12.00
12.01	Medical Social Services								12.01
13.00	Home Health Aide								13.00
13.01	Home Health Aide								13.01
14.00	Total (sum of lines 8-13)								14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0213

Period:

Worksheet H-3

HHA CCN: 14-7452

From 10/01/2020
To 09/30/2021Part II
Date/Time Prepared:
2/28/2022 12:24 pm

Title XVIII

Home Health
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Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
	0	1.00	2.00	3.00	4.00		
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00 Physical Therapy	66.00	0.220177	1,738,767	382,837	col. 2, line 2.00		1.00
2.00 Occupational Therapy	67.00	0.246393	702,340	173,052	col. 2, line 3.00		2.00
3.00 Speech Pathology	68.00	0.000000	0	0	col. 2, line 4.00		3.00
4.00 Cost of Medical Supplies	71.00	0.634875	29,140	18,500	col. 2, line 15.00		4.00
5.00 Cost of Drugs	73.00	0.360996	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0213 HHA CCN: 14-7452	Period: From 10/01/2020 To 09/30/2021	Worksheet H-4 Part I-II Date/Time Prepared: 2/28/2022 12:24 pm
		Title XVIII	Home Health Agency I	PPS
		Part A	Part B	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		1.00	2.00	3.00
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0
2.00	Total charges	0	0	0
Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(b)	0	0	0
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000
6.00	Total customary charges (see instructions)	0	0	0
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0
9.00	Primary payer amounts	0	0	0
			Part A Services	Part B Services
			1.00	2.00
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT				
10.00	Total reasonable cost (see instructions)		0	0
11.00	Total PPS Reimbursement - Full Episodes without Outliers		0	2,547,159
12.00	Total PPS Reimbursement - Full Episodes with Outliers		0	151,918
13.00	Total PPS Reimbursement - LUPA Episodes		0	34,875
14.00	Total PPS Reimbursement - PEP Episodes		0	12,193
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		0	36,849
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	0
17.00	Total Other Payments		0	0
18.00	DME Payments		0	0
19.00	Oxygen Payments		0	0
20.00	Prosthetic and Orthotic Payments		0	0
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	0
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		0	2,782,994
23.00	Excess reasonable cost (from line 8)		0	0
24.00	Subtotal (line 22 minus line 23)		0	2,782,994
25.00	Coinsurance billed to program patients (from your records)		0	0
26.00	Net cost (line 24 minus line 25)		0	2,782,994
27.00	Reimbursable bad debts (from your records)		0	0
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	0
29.00	Total costs - current cost reporting period (line 26 plus line 27)		0	2,782,994
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	-2,080
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	0
30.99	Demonstration payment adjustment amount before sequestration		0	0
31.00	Subtotal (see instructions)		0	2,780,914
31.01	Sequestration adjustment (see instructions)		0	0
31.02	Demonstration payment adjustment amount after sequestration		0	0
31.75	Sequestration adjustment for non-claims based amounts (see instructions)		0	0
32.00	Interim payments (see instructions)		0	2,780,914
33.00	Tentative settlement (for contractor use only)		0	0
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)		0	0
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAS FOR SERVICES RENDERED
TO PROGRAM BENEFICIARIES

Provider CCN: 14-0213

Period:

Worksheet H-5

HHA CCN: 14-7452

From 10/01/2020

Date/Time Prepared:

To 09/30/2021

2/28/2022 12:24 pm

Home Health
Agency I

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		2,780,914	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		2,780,914	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		2,780,914	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0213	Period: From 10/01/2020 To 09/30/2021	Worksheet L Parts I-III Date/Time Prepared: 2/28/2022 12:24 pm
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		5,378,406	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		78,413	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)		218.74	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		2.11	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		14.67	8.00
9.00	Sum of lines 7 and 8		16.78	9.00
10.00	Allowable disproportionate share percentage (see instructions)		3.46	10.00
11.00	Disproportionate share adjustment (see instructions)		186,093	11.00
12.00	Total prospective capital payments (see instructions)		5,642,912	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