

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

FORM APPROVED

OMB NO. 0938-0050

EXPIRES 03-31-2022

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-0239	Period: From 07/01/2020 To 06/30/2021	Worksheet S Parts I-III Date/Time Prepared: 4/27/2022 12:54 pm
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 4/27/2022	Time: 12:54 pm
	2. ☐ Manually prepared cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☐ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION 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 JAVON BEA HOSPITAL (14-0239) for the cost reporting period beginning 07/01/2020 and ending 06/30/2021 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINANCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONIC SIGNATURE STATEMENT	
	1	2		
1			I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name			2
3	Signatory Title			3
4	Date			4

Cost Center Description	Title V	Title XVIII		HIT	Title XIX	
		Part A	Part B			
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	4,443,994	595,295	0	0	1.00
2.00 Subprovider - IPF	0	9,924	0		0	2.00
3.00 Subprovider - IRF	0	0	0		0	3.00
5.00 Swing Bed - SNF	0	0	0		0	5.00
6.00 Swing Bed - NF	0				0	6.00
7.00 SKILLED NURSING FACILITY	0	0	0		0	7.00
200.00 Total	0	4,453,918	595,295	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0239		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 4/27/2022 12:54 pm	
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 2400 N ROCKTON AVENUE			PO Box:				1.00	
2.00	City: ROCKFORD			State: IL		Zip Code: 61103		County: WINNEBAGO	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)	
								V	XVIII
								XIX	
		1.00		2.00	3.00	4.00	5.00	6.00	7.00
Hospital and Hospital-Based Component Identification:									
3.00	Hospital			JAVON BEA HOSPITAL	140239	40420	1	07/01/1966	N
4.00	Subprovider - IPF			PSYCHIATRIC UNIT	14S239	40420	4	03/01/1990	N
5.00	Subprovider - IRF								P
6.00	Subprovider - (Other)								O
7.00	Swing Beds - SNF								
8.00	Swing Beds - NF								
9.00	Hospital-Based SNF			JAVON BEA HOSPITAL SNF	146196	40420		06/30/2021	N
10.00	Hospital-Based NF								P
11.00	Hospital-Based OLTC								O
12.00	Hospital-Based HHA								
13.00	Separately Certified ASC								
14.00	Hospital-Based Hospice								
15.00	Hospital-Based Health Clinic - RHC								
16.00	Hospital-Based Health Clinic - FQHC								
17.00	Hospital-Based (CMHC) I								
17.10	Hospital-Based (CORF) I								
17.20	Hospital-Based (OPT) I								
17.30	Hospital-Based (OOT) I								
17.40	Hospital-Based (OSP) I								
18.00	Renal Dialysis								
19.00	Other								
							From:	To:	
							1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)						07/01/2020		06/30/2021
21.00	Type of Control (see instructions)						2		
							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		
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	Y		
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N	
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	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					3	N		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0239

Period:
From 07/01/2020
To 06/30/2021Worksheet S-2
Part I
Date/Time Prepared:
4/27/2022 12:54 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.	1,383	2,462	0	2,039	7,829	0	24.00
25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0	0	0	0		25.00
					Urban/Rural S	Date of Geogr	
					1.00	2.00	
26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					1		26.00
27.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					1		27.00
35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00
					Beginning:	Ending:	
					1.00	2.00	
36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00
37.00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00
37.01 Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01
38.00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00
					Y/N	Y/N	
					1.00	2.00	
39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00
40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					Y	Y	40.00
					V	XVIII	XIX
					1.00	2.00	3.00
Prospective Payment System (PPS)-Capital							
45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	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.					Y	Y	
57.00 If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					N		
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: 14-0239

Period:
From 07/01/2020
To 06/30/2021Worksheet S-2
Part I
Date/Time Prepared:
4/27/2022 12:54 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	
60.02	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		23.02	1	60.02	
		Y/N	IME	Direct GME	IME	Direct GME
		1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)					
61.02	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)					
61.03	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)					
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).					
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)					
61.06	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)					
		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

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

Health Financial Systems		JAVON BEA HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0239	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part I Date/Time Prepared: 4/27/2022 12:54 pm	
			1.00	2.00	3.00
Inpatient Psychiatric Facility PPS					
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	Y			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N	N	0	71.00
Inpatient Rehabilitation Facility PPS					
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	N			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)			0	76.00
			1.00		
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.		N		80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.		N		81.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.		N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N		87.00
			V	XIX	
			1.00	2.00	
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	N		90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N		91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N		92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N		94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N		96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00		97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N		98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N		98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N		98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N		98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N		98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N		98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N		98.06
Rural Providers					
105.00	Does this hospital qualify as a CAH?	N			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)				106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)				107.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0239		Period: From 07/01/2020 To 06/30/2021		Worksheet S-2 Part I Date/Time Prepared: 4/27/2022 12:54 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	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
				1.00	2.00	3.00	
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.			N			0115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.			N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.			Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.			2			118.00
				Premiums	Losses	Insurance	
				1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:			1,476,550	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
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.			N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.						129.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0239	Period: From 07/01/2020 To 06/30/2021	Worksheet S-2 Part I Date/Time Prepared: 4/27/2022 12:54 pm		
		1.00	2.00			
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00	
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00	
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00	
133.00	Removed and reserved				133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00	
All Providers						
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	HB0764		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: MERCY ROCKFORD HEALTH SYSTEM	Contractor's Name: NGS	Contractor's Number: 00450		141.00	
142.00	Street: 2400 NORTH ROCKTON AVENUE	PO Box:			142.00	
143.00	City: ROCKFORD	State: IL	Zip Code: 61103		143.00	
				1.00		
144.00	Are provider based physicians' costs included in Worksheet A?	Y			144.00	
				1.00 2.00		
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	Y	N		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 1.00	Part B 2.00	Title V 3.00	Title XIX 4.00	
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)						
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00
161.10	CORF		N	N	N	161.10
161.20	OUTPATIENT PHYSICAL THERAPY		N	N	N	161.20
161.30	OUTPATIENT OCCUPATIONAL THERAPY		N	N	N	161.30
161.40	OUTPATIENT SPEECH PATHOLOGY		N	N	N	161.40
				1.00		
Multicampus						
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N			165.00	
		Name 0	County 1.00	State 2.00	Zip Code 3.00	CBSA 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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0239

Period:
From 07/01/2020
To 06/30/2021Worksheet S-2
Part I
Date/Time Prepared:
4/27/2022 12:54 pm

		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
		Beginning	Ending
		1.00	2.00
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)		170.00
		1.00	2.00
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0239

Period:
From 07/01/2020
To 06/30/2021Worksheet S-2
Part II
Date/Time Prepared:
4/27/2022 12:54 pm

		Y/N	Date	
		1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N	Date	V/I
		1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y		3.00
		Y/N	Type	Date
		1.00	2.00	3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	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	Legal Oper.	
		1.00	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.	Y		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
		Y/N		
		1.00		
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y		12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N		13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N		14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	Y		15.00
		Part A		Part B
		Y/N	Date	Y/N
		1.00	2.00	3.00
				4.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	10/19/2021	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: 14-0239

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To 06/30/2021Worksheet S-2
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		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?				36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	AMY	SEACRIST		41.00
42.00	Enter the employer/company name of the cost report preparer.	MERCY HEALTH SYSTEM			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	815-971-5010	ASEACRIST@MHEMAIL.ORG		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0239

Period:
From 07/01/2020
To 06/30/2021Worksheet S-2
Part II
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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.	DIRECTOR OF REIMBURSEMENT	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0239

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part I
Date/Time Prepared:
4/27/2022 12:54 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	154	57,704	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)		154	57,704	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	18	10,151	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
11.01 NEONATAL INTENSIVE CARE	34.01	52	18,980	0.00	0	11.01
11.02 PEDIATRIC INTENSIVE CARE	34.02	0	0	0.00	0	11.02
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		224	86,835	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	0	186		0	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	44.00	17	366		0	19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	99.10				0	25.10
25.20 CMHC - OUTPATIENT PHYSICAL THERAPY	99.20				0	25.20
25.30 CMHC - OUTPATIENT OCCUPATIONAL THERAPY	99.30				0	25.30
25.40 CMHC - OUTPATIENT SPEECH PATHOLOGY	99.40				0	25.40
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		241			0	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)		10	3,650			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0239

Period:
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To 06/30/2021Worksheet S-3
Part I
Date/Time Prepared:
4/27/2022 12:54 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)	10,372	2,562	31,539			1.00
2.00	HMO and other (see instructions)	9,064	7,829				2.00
3.00	HMO IPF Subprovider	31	11				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	10,372	2,562	31,539			7.00
8.00	INTENSIVE CARE UNIT	1,663	438	5,333			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
11.01	NEONATAL INTENSIVE CARE	0	2,258	9,653			11.01
11.02	PEDIATRIC INTENSIVE CARE	0	0	0			11.02
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		458	1,530			13.00
14.00	Total (see instructions)	12,035	5,716	48,055	48.97	1,388.25	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	13	11	74	0.00	3.26	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0	0	0	0.00	0.00	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			154			24.10
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	0	0	0	0.00	0.00	25.10
25.20	CMHC - OUTPATIENT PHYSICAL THERAPY	0	0	0	0.00	0.00	25.20
25.30	CMHC - OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0.00	0.00	25.30
25.40	CMHC - OUTPATIENT SPEECH PATHOLOGY	0	0	0	0.00	0.00	25.40
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				48.97	1,391.51	27.00
28.00	Observation Bed Days		0	5,795			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	168	1,273			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0239

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part I
Date/Time Prepared:
4/27/2022 12:54 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	2,423	762	7,564	1.00
2.00 HMO and other (see instructions)			1,556	1,473		2.00
3.00 HMO IPF Subprovider				2		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
11.01 NEONATAL INTENSIVE CARE						11.01
11.02 PEDIATRIC INTENSIVE CARE						11.02
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	2,423	762	7,564	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	2	2	19	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	0.00					19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	0.00					25.10
25.20 CMHC - OUTPATIENT PHYSICAL THERAPY	0.00					25.20
25.30 CMHC - OUTPATIENT OCCUPATIONAL THERAPY	0.00					25.30
25.40 CMHC - OUTPATIENT SPEECH PATHOLOGY	0.00					25.40
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0239

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part II
Date/Time Prepared:
4/27/2022 12:54 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	96,316,017	0	96,316,017	2,894,344.62	33.28
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		126,215	0	126,215	2,070.48	60.96
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	3,036,483	3,036,483	104,244.00	29.13
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	112,084	0	112,084	2,774.70	40.39
10.00	Excluded area salaries (see instructions)		2,806,355	126,734	2,933,089	68,984.79	42.52
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		326,456	0	326,456	1,818.50	179.52
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		0	0	0	0.00	0.00
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		17,249,432	0	17,249,432	415,311.00	41.53
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)		18,646,541	0	18,646,541		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		569,522	0	569,522		
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		20,870	0	20,870		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		666,818	0	666,818		
25.50	Home office wage-related (core)		5,071,010	0	5,071,010		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0239

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part II
Date/Time Prepared:
4/27/2022 12:54 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	1,745	0	1,745	151.00	11.56	26.00
27.00	Administrative & General	5.00	12,323,633	-9,479,826	2,843,807	135,611.17	20.97	27.00
28.00	Administrative & General under contract (see inst.)		744,547	0	744,547	2,523.21	295.08	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,203,229	280,976	1,484,205	48,726.14	30.46	30.00
31.00	Laundry & Linen Service	8.00	103,029	0	103,029	7,002.00	14.71	31.00
32.00	Housekeeping	9.00	2,484,437	0	2,484,437	165,772.00	14.99	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	1,707,048	-843,290	863,758	46,067.61	18.75	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	943,309	943,309	56,899.00	16.58	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	2,445,539	159,805	2,605,344	65,449.29	39.81	38.00
39.00	Central Services and Supply	14.00	1,347,139	250,899	1,598,038	80,966.43	19.74	39.00
40.00	Pharmacy	15.00	3,742,460	261,267	4,003,727	82,652.43	48.44	40.00
41.00	Medical Records & Medical Records Library	16.00	1,116,222	23,464	1,139,686	39,109.92	29.14	41.00
42.00	Social Service	17.00	79,120	0	79,120	3,612.00	21.90	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0239

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part III
Date/Time Prepared:
4/27/2022 12:54 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)	96,934,349	-3,036,483	93,897,866	2,790,553.35	33.65	1.00
2.00	Excluded area salaries (see instructions)	2,918,439	126,734	3,045,173	71,759.49	42.44	2.00
3.00	Subtotal salaries (line 1 minus line 2)	94,015,910	-3,163,217	90,852,693	2,718,793.86	33.42	3.00
4.00	Subtotal other wages & related costs (see inst.)	17,575,888	0	17,575,888	417,129.50	42.14	4.00
5.00	Subtotal wage-related costs (see inst.)	23,717,551	0	23,717,551	0.00	26.11	5.00
6.00	Total (sum of lines 3 thru 5)	135,309,349	-3,163,217	132,146,132	3,135,923.36	42.14	6.00
7.00	Total overhead cost (see instructions)	27,298,148	-8,403,396	18,894,752	734,542.20	25.72	7.00

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	3,654,727	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	286	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	1,804,599	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)			
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	7,828,905	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	426,958	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	45,225	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)	505,191	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	0	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	518,749	16.00
TAXES			
17.00	FICA-Employers Portion Only	6,939,727	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	-455,287	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	439,271	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	21,708,351	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: 14-0239

Period:
From 07/01/2020
To 06/30/2021Worksheet S-3
Part V
Date/Time Prepared:
4/27/2022 12:54 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	326,456	21,708,351	1.00
2.00	Hospital	326,456	21,708,351	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	0	0	8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
16.10	Hospital-Based-CMHC 10	0	0	16.10
16.20	Hospital-Based-CMHC 20	0	0	16.20
16.30	Hospital-Based-CMHC 30	0	0	16.30
16.40	Hospital-Based-CMHC 40	0	0	16.40
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 14-0239

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

Worksheet S-10

Date/Time Prepared:
4/27/2022 12:54 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)		0.193853	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		60,427,868	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		N	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		27,795,420	5.00
6.00	Medicaid charges		221,432,882	6.00
7.00	Medicaid cost (line 1 times line 6)		42,925,428	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		0	8.00
Children's Health Insurance Program (CHIP) (see instructions for each line)				
9.00	Net revenue from stand-alone CHIP		0	9.00
10.00	Stand-alone CHIP charges		0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)		0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00
Other state or local government indigent care program (see instructions for each line)				
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00
Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)				
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		0	19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)
		1.00	2.00	3.00
Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	6,107,307	1,088,047	7,195,354
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	1,183,920	1,088,047	2,271,967
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)	1,183,920	1,088,047	2,271,967
			1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit		0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		23,756,263	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		1,071,519	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		1,648,491	27.01
28.00	Non-Medicare bad debt expense (see instructions)		22,107,772	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		4,862,630	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		7,134,597	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		7,134,597	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0239

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

Worksheet A

Date/Time Prepared:
4/27/2022 12:54 pm

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		0	0	583,799	583,799	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	31,223,410	31,223,410	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,745	13,609,526	13,611,271	0	13,611,271	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	12,323,633	138,974,395	151,298,028	-42,661,846	108,636,182	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	1,203,229	6,893,006	8,096,235	280,976	8,377,211	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	103,029	1,003,034	1,106,063	0	1,106,063	8.00
9.00	00900	HOUSEKEEPING	2,484,437	1,206,343	3,690,780	0	3,690,780	9.00
10.00	01000	DIETARY	1,707,048	1,176,268	2,883,316	-1,493,292	1,390,024	10.00
11.00	01100	CAFETERIA	0	0	0	1,593,311	1,593,311	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	2,445,539	293,077	2,738,616	159,805	2,898,421	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,347,139	1,286,699	2,633,838	-735,783	1,898,055	14.00
15.00	01500	PHARMACY	3,742,460	19,665,001	23,407,461	-17,395,977	6,011,484	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,116,222	477,813	1,594,035	23,464	1,617,499	16.00
17.00	01700	SOCIAL SERVICE	79,120	7,656	86,776	0	86,776	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	3,036,483	3,036,483	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	4,463,496	4,463,496	22.00
23.00	02300	PARAMDICAL ED PROGRAM XRAY	310,774	45,240	356,014	0	356,014	23.00
23.01	02301	PASTORAL EDUCATION PROGRAM	0	0	0	0	0	23.01
23.02	02302	PARAMED EDUC EMT PROGRAM	423,475	397,049	820,524	76,458	896,982	23.02
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	18,292,908	3,328,446	21,621,354	-2,344,484	19,276,870	30.00
31.00	03100	INTENSIVE CARE UNIT	4,511,429	1,247,236	5,758,665	-627,715	5,130,950	31.00
34.01	03401	NEONATAL INTENSIVE CARE	6,455,407	1,341,620	7,797,027	-1,220,988	6,576,039	34.01
34.02	03402	PEDIATRIC INTENSIVE CARE	6,005	2,031	8,036	28,474	36,510	34.02
40.00	04000	SUBPROVIDER - IPF	214,177	17,800	231,977	7,688	239,665	40.00
43.00	04300	NURSERY	0	0	0	2,401,671	2,401,671	43.00
44.00	04400	SKILLED NURSING FACILITY	112,084	71,531	183,615	0	183,615	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	7,433,012	16,515,537	23,948,549	-7,934,372	16,014,177	50.00
51.00	05100	RECOVERY ROOM	943,605	112,084	1,055,689	3,057	1,058,746	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,644,989	2,131,887	4,776,876	-202,125	4,574,751	52.00
53.00	05300	ANESTHESIOLOGY	619,941	2,639,376	3,259,317	-771,163	2,488,154	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,264,648	8,741,439	13,006,087	-7,972,356	5,033,731	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,023,742	351,911	1,375,653	-68,957	1,306,696	55.00
56.00	05600	RADIOISOTOPE	218,235	745,160	963,395	0	963,395	56.00
57.00	05700	CT SCAN	1,256,244	433,665	1,689,909	-217,253	1,472,656	57.00
58.00	05800	MRI	713,598	102,429	816,027	0	816,027	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	3,900,253	9,755,686	13,655,939	148,929	13,804,868	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	296,836	56,846	353,682	24,643	378,325	64.00
65.00	06500	RESPIRATORY THERAPY	2,137,046	925,495	3,062,541	-210,628	2,851,913	65.00
66.00	06600	PHYSICAL THERAPY	1,746,509	151,861	1,898,370	0	1,898,370	66.00
69.00	06900	ELECTROCARDIOLOGY	1,255,713	224,439	1,480,152	47,528	1,527,680	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	545,181	238,633	783,814	78,956	862,770	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	13,937,887	13,937,887	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	9,561,338	9,561,338	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	17,657,244	17,657,244	73.00
73.01	07301	INJECTABLE DRUGS	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	8,665	671,339	680,004	11,711	691,715	74.00
76.00	03340	GI LAB	951,700	1,186,194	2,137,894	-748,618	1,389,276	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09003	PAIN CENTER	637,881	276,554	914,435	-169,264	745,171	90.01
90.02	09001	ANTENATAL TEST CENTER	530,703	114,952	645,655	0	645,655	90.02
90.03	09002	CHILD PSYCHIATRIC CLINIC	107,636	9,572	117,208	0	117,208	90.03
90.04	09004	SPECIAL SURGICAL SERVICES	309,060	220,054	529,114	-62,019	467,095	90.04
90.05	09005	GENETIC SERVICES	279,422	22,651	302,073	0	302,073	90.05
90.06	09006	HBP	0	0	0	0	0	90.06
90.07	09007	MAIN	0	0	0	0	0	90.07
90.08	09008	RMB	0	0	0	0	0	90.08
90.09	09009	MULFORD	0	0	0	0	0	90.09

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0239

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

Worksheet A

Date/Time Prepared:
4/27/2022 12:54 pm

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
90.10	09010	ALPINE	0	0	0	0	0	90.10
90.11	09011	ROSCOE	0	0	0	0	0	90.11
90.12	09012	BYRON	0	0	0	0	0	90.12
90.13	09013	WINNEBAGO	0	0	0	0	0	90.13
90.14	09014	PERRYVILLE	0	0	0	0	0	90.14
90.15	09015	BELVIDERE	0	0	0	0	0	90.15
90.16	09016	SPRINGBROOK	0	0	0	0	0	90.16
90.17	09017	MCFARLAND	0	0	0	0	0	90.17
90.18	09018	CHERRYVALLEY	0	0	0	0	0	90.18
90.19	09019	KLECKNER	0	0	0	0	0	90.19
90.20	09020	GALLERIA	0	0	0	0	0	90.20
90.21	09021	RIVERSIDE MOB	0	0	0	0	0	90.21
90.22	09022	MULFORD-LENOX	0	0	0	0	0	90.22
91.00	09100	EMERGENCY	5,753,609	4,675,008	10,428,617	-555,818	9,872,799	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	1,050,783	630,411	1,681,194	10,353	1,691,547	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	95,508,871	241,976,954	337,485,825	-31,977	337,453,848	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.01	19301	BELOIT HEART STANDBY	21,303	1,234	22,537	0	22,537	193.01
194.00	07950	GUEST CENTER	0	219,392	219,392	0	219,392	194.00
194.01	07954	OTHER NONREIMBURSEABLE COST CENTER	57,528	6,550	64,078	0	64,078	194.01
194.02	07951	COMMUNITY SERVICES	163,315	481,238	644,553	0	644,553	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERSO	0	0	0	0	0	194.03
194.04	07952	AUXILIARY	35,388	78,043	113,431	31,977	145,408	194.04
194.05	07956	RETAIL PHARMACY	529,612	9,561,733	10,091,345	0	10,091,345	194.05
194.08	07955	DIALYSIS RENTED SPACE	0	0	0	0	0	194.08
200.00		TOTAL (SUM OF LINES 118 through 199)	96,316,017	252,325,144	348,641,161	0	348,641,161	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0239

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

Worksheet A

Date/Time Prepared:
4/27/2022 12:54 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	0	583,799	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	31,223,410	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	5,156,520	18,767,791	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-78,244,765	30,391,417	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	8,377,211	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,106,063	8.00
9.00	00900	HOUSEKEEPING	0	3,690,780	9.00
10.00	01000	DIETARY	0	1,390,024	10.00
11.00	01100	CAFETERIA	-1,223,271	370,040	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	2,898,421	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,118,136	3,016,191	14.00
15.00	01500	PHARMACY	0	6,011,484	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,673,118	3,290,617	16.00
17.00	01700	SOCIAL SERVICE	0	86,776	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	3,036,483	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	4,463,496	22.00
23.00	02300	PARAMDICAL ED PROGRAM XRAY	-109,555	246,459	23.00
23.01	02301	PASTORAL EDUCATION PROGRAM	0	0	23.01
23.02	02302	PARAMED EDUC EMT PROGRAM	-166,914	730,068	23.02
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-1,328	19,275,542	30.00
31.00	03100	INTENSIVE CARE UNIT	0	5,130,950	31.00
34.01	03401	NEONATAL INTENSIVE CARE	-20,510	6,555,529	34.01
34.02	03402	PEDIATRIC INTENSIVE CARE	0	36,510	34.02
40.00	04000	SUBPROVIDER - IPF	0	239,665	40.00
43.00	04300	NURSERY	0	2,401,671	43.00
44.00	04400	SKILLED NURSING FACILITY	0	183,615	44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	16,014,177	50.00
51.00	05100	RECOVERY ROOM	0	1,058,746	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-1,297,428	3,277,323	52.00
53.00	05300	ANESTHESIOLOGY	-1,703,118	785,036	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-22,253	5,011,478	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	1,306,696	55.00
56.00	05600	RADIOISOTOPE	0	963,395	56.00
57.00	05700	CT SCAN	0	1,472,656	57.00
58.00	05800	MRI	0	816,027	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	-3,011,677	10,793,191	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	378,325	64.00
65.00	06500	RESPIRATORY THERAPY	-5,943	2,845,970	65.00
66.00	06600	PHYSICAL THERAPY	-229	1,898,141	66.00
69.00	06900	ELECTROCARDIOLOGY	-173	1,527,507	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	862,770	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	13,937,887	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	9,561,338	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1	17,657,245	73.00
73.01	07301	INJECTABLE DRUGS	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	691,715	74.00
76.00	03340	GI LAB	0	1,389,276	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
90.01	09003	PAIN CENTER	-17,578	727,593	90.01
90.02	09001	ANTENATAL TEST CENTER	0	645,655	90.02
90.03	09002	CHILD PSYCHIATRIC CLINIC	-83,850	33,358	90.03
90.04	09004	SPECIAL SURGICAL SERVICES	0	467,095	90.04
90.05	09005	GENETIC SERVICES	0	302,073	90.05
90.06	09006	HBP	277,376	277,376	90.06
90.07	09007	MAIN	1,216,789	1,216,789	90.07
90.08	09008	RMB	107,611	107,611	90.08
90.09	09009	MULFORD	147,604	147,604	90.09
90.10	09010	ALPINE	137,247	137,247	90.10
90.11	09011	ROSCOE	119,631	119,631	90.11

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0239

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

Worksheet A

Date/Time Prepared:
4/27/2022 12:54 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
90.12	09012	BYRON	31,369	31,369	90.12
90.13	09013	WINNEBAGO	111,982	111,982	90.13
90.14	09014	PERRYVILLE	650,207	650,207	90.14
90.15	09015	BELVIDERE	34,917	34,917	90.15
90.16	09016	SPRINGBROOK	253,538	253,538	90.16
90.17	09017	MCFARLAND	16,092	16,092	90.17
90.18	09018	CHERRYVALLEY	58,625	58,625	90.18
90.19	09019	KLECKNER	0	0	90.19
90.20	09020	GALLERIA	125,879	125,879	90.20
90.21	09021	RIVERSIDE MOB	315,852	315,852	90.21
90.22	09022	MULFORD-LENOX	11,094	11,094	90.22
91.00	09100	EMERGENCY	-2,840,293	7,032,506	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	-1,014,798	676,749	95.00
99.10	09910	CORF	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	99.40
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-78,200,095	259,253,753	118.00
NONREIMBURSABLE COST CENTERS					
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
193.01	19301	BELOIT HEART STANDBY	0	22,537	193.01
194.00	07950	GUEST CENTER	0	219,392	194.00
194.01	07954	OTHER NONREIMBURSEABLE COST CENTER	0	64,078	194.01
194.02	07951	COMMUNITY SERVICES	0	644,553	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERSO	0	0	194.03
194.04	07952	AUXILIARY	0	145,408	194.04
194.05	07956	RETAIL PHARMACY	0	10,091,345	194.05
194.08	07955	DIALYSIS RENTED SPACE	0	0	194.08
200.00		TOTAL (SUM OF LINES 118 through 199)	-78,200,095	270,441,066	200.00

Increases					
Cost Center	Line #	Salary	Other		
2.00	3.00	4.00	5.00		
A - DRUGS CHARGED TO PATIENTS					
1.00 DRUGS CHARGED TO PATIENTS	73.00	0	17,657,244		1.00
TOTALS		0	17,657,244		
E - SHARED DIETARY EXPENSES					
1.00 CAFETERIA	11.00	943,309	650,002		1.00
TOTALS		943,309	650,002		
F - RECLASS MED SUPPLIES CHGD PAT					
1.00 MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	13,937,887		1.00
2.00	0.00	0	0		2.00
3.00	0.00	0	0		3.00
4.00	0.00	0	0		4.00
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
14.00	0.00	0	0		14.00
16.00	0.00	0	0		16.00
17.00	0.00	0	0		17.00
19.00	0.00	0	0		19.00
21.00	0.00	0	0		21.00
22.00	0.00	0	0		22.00
23.00	0.00	0	0		23.00
24.00	0.00	0	0		24.00
TOTALS		0	13,937,887		
G - NURSERY COSTS					
1.00 NURSERY	43.00	2,054,071	347,600		1.00
2.00	0.00	0	0		2.00
TOTALS		2,054,071	347,600		
H - DEPARTMENTAL DEPRECIATION					
1.00 CAP REL COSTS-MVBLE EQUIP	2.00	0	31,223,410		1.00
2.00	0.00	0	0		2.00
TOTALS		0	31,223,410		
I - INSURANCE RECLASS					
1.00 CAP REL COSTS-BLDG & FIXT	1.00	0	583,799		1.00
TOTALS		0	583,799		
K - IMPLANTS					
1.00 IMPL. DEV. CHARGED TO PATIENTS	72.00	0	9,561,338		1.00
2.00	0.00	0	0		2.00
3.00	0.00	0	0		3.00
TOTALS		0	9,561,338		
O - INTERNS AND RESIDENTS					
1.00 I&R SERVICES-SALARY & FRINGES APPRV	21.00	3,036,483	0		1.00
2.00 I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	3,043,989	1,419,507		2.00
TOTALS		6,080,472	1,419,507		
P - DIRECTOR AND MANAGER					
1.00 OPERATION OF PLANT	7.00	280,976	0		1.00
4.00 DIETARY	10.00	100,019	0		4.00
5.00 NURSING ADMINISTRATION	13.00	159,805	0		5.00
6.00 CENTRAL SERVICES & SUPPLY	14.00	250,899	0		6.00
7.00 PHARMACY	15.00	261,267	0		7.00
8.00 MEDICAL RECORDS & LIBRARY	16.00	23,464	0		8.00
9.00 PARAMED EDUC EMT PROGRAM	23.02	76,458	0		9.00
10.00 ADULTS & PEDIATRICS	30.00	610,155	0		10.00
11.00 INTENSIVE CARE UNIT	31.00	76,885	0		11.00
12.00 NEONATAL INTENSIVE CARE	34.01	93,173	0		12.00
13.00 PEDIATRIC INTENSIVE CARE	34.02	28,474	0		13.00
14.00 SUBPROVIDER - IPF	40.00	7,946	0		14.00
15.00 OPERATING ROOM	50.00	311,106	0		15.00
16.00 RECOVERY ROOM	51.00	25,589	0		16.00
17.00 DELIVERY ROOM & LABOR ROOM	52.00	130,112	0		17.00
18.00 ANESTHESIOLOGY	53.00	14,714	0		18.00
19.00 RADIOLOGY-DIAGNOSTIC	54.00	167,123	0		19.00
20.00 RADIOLOGY-THERAPEUTIC	55.00	21,351	0		20.00
21.00 LABORATORY	60.00	148,929	0		21.00
22.00 INTRAVENOUS THERAPY	64.00	32,946	0		22.00
23.00 RESPIRATORY THERAPY	65.00	137,330	0		23.00
24.00 ELECTROCARDIOLOGY	69.00	61,486	0		24.00

Provider CCN: 14-0239

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

Worksheet A-6

Date/Time Prepared:
4/27/2022 12:54 pm

Increases						
Cost Center	Line #	Salary	Other			
2.00	3.00	4.00	5.00			
25.00	ELECTROENCEPHALOGRAPHY	70.00	78,956	0		25.00
26.00	RENAL DIALYSIS	74.00	11,711	0		26.00
27.00	GI LAB	76.00	91,402	0		27.00
28.00	PAIN CENTER	90.01	50,288	0		28.00
29.00	SPECIAL SURGICAL SERVICES	90.04	29,277	0		29.00
30.00	EMERGENCY	91.00	75,183	0		30.00
31.00	AMBULANCE SERVICES	95.00	10,353	0		31.00
33.00	AUXILIARY	194.04	31,977	0		33.00
	TOTALS		3,399,354	0		
500.00	Grand Total: Increases		12,477,206	75,380,787		500.00

RECLASSIFICATIONS

Provider CCN: 14-0239

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

Worksheet A-6

Date/Time Prepared:
4/27/2022 12:54 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - DRUGS CHARGED TO PATIENTS						
1.00	PHARMACY	15.00	0	17,657,244	0		1.00
	TOTALS		0	17,657,244			
	E - SHARED DIETARY EXPENSES						
1.00	DIETARY	10.00	943,309	650,002	0		1.00
	TOTALS		943,309	650,002			
	F - RECLASS MED SUPPLIES CHGD PAT						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	986,682	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	1,160,211	0		2.00
3.00	INTENSIVE CARE UNIT	31.00	0	704,600	0		3.00
4.00	NEONATAL INTENSIVE CARE	34.01	0	662,222	0		4.00
6.00	SUBPROVIDER - IPF	40.00	0	258	0		6.00
7.00	OPERATING ROOM	50.00	0	639,892	0		7.00
8.00	RECOVERY ROOM	51.00	0	22,532	0		8.00
9.00	DELIVERY ROOM & LABOR ROOM	52.00	0	332,237	0		9.00
10.00	ANESTHESIOLOGY	53.00	0	785,822	0		10.00
11.00	RADIOLOGY-DIAGNOSTIC	54.00	0	6,183,782	0		11.00
12.00	RADIOLOGY-THERAPEUTIC	55.00	0	90,308	0		12.00
14.00	CT SCAN	57.00	0	217,253	0		14.00
16.00	INTRAVENOUS THERAPY	64.00	0	8,303	0		16.00
17.00	RESPIRATORY THERAPY	65.00	0	347,958	0		17.00
19.00	ELECTROCARDIOLOGY	69.00	0	13,958	0		19.00
21.00	GI LAB	76.00	0	840,020	0		21.00
22.00	PAIN CENTER	90.01	0	219,552	0		22.00
23.00	SPECIAL SURGICAL SERVICES	90.04	0	91,296	0		23.00
24.00	EMERGENCY	91.00	0	631,001	0		24.00
	TOTALS		0	13,937,887			
	G - NURSERY COSTS						
1.00	ADULTS & PEDIATRICS	30.00	1,511,010	238,722	0		1.00
2.00	NEONATAL INTENSIVE CARE	34.01	543,061	108,878	0		2.00
	TOTALS		2,054,071	347,600			
	H - DEPARTMENTAL DEPRECIATION						
1.00		0.00	0	0	9		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	31,223,410	0		2.00
	TOTALS		0	31,223,410			
	I - INSURANCE RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	583,799	12		1.00
	TOTALS		0	583,799			
	K - IMPLANTS						
1.00	OPERATING ROOM	50.00	0	7,605,586	0		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,955,697	0		2.00
3.00	ANESTHESIOLOGY	53.00	0	55	0		3.00
	TOTALS		0	9,561,338			
	O - INTERNS AND RESIDENTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	6,080,472	1,374,811	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	44,696	0		2.00
	TOTALS		6,080,472	1,419,507			
	P - DIRECTOR AND MANAGER						
1.00	ADMINISTRATIVE & GENERAL	5.00	3,399,354	0	0		1.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
16.00		0.00	0	0	0		16.00
17.00		0.00	0	0	0		17.00
18.00		0.00	0	0	0		18.00
19.00		0.00	0	0	0		19.00
20.00		0.00	0	0	0		20.00
21.00		0.00	0	0	0		21.00
22.00		0.00	0	0	0		22.00
23.00		0.00	0	0	0		23.00
24.00		0.00	0	0	0		24.00
25.00		0.00	0	0	0		25.00
26.00		0.00	0	0	0		26.00
27.00		0.00	0	0	0		27.00
28.00		0.00	0	0	0		28.00

Provider CCN: 14-0239

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

Worksheet A-6

Date/Time Prepared:
4/27/2022 12:54 pm

	Decreases				Wkst. A-7 Ref.	
	Cost Center	Line #	Salary	Other		
	6.00	7.00	8.00	9.00	10.00	
29.00		0.00	0	0	0	29.00
30.00		0.00	0	0	0	30.00
31.00		0.00	0	0	0	31.00
33.00		0.00	0	0	0	33.00
	TOTALS		3,399,354	0		
500.00	Grand Total: Decreases		12,477,206	75,380,787		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0239

Period:
From 07/01/2020
To 06/30/2021Worksheet A-7
Part I
Date/Time Prepared:
4/27/2022 12:54 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	8,374,625	0	0	0	205,859	1.00	
2.00	Land Improvements	12,096,922	862,766	0	862,766	0	2.00	
3.00	Buildings and Fixtures	412,766,850	0	0	0	10,580,678	3.00	
4.00	Building Improvements	947,421	17,892	0	17,892	0	4.00	
5.00	Fixed Equipment	169,932,431	8,677,306	0	8,677,306	0	5.00	
6.00	Movable Equipment	246,620,740	5,895,581	0	5,895,581	0	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	850,738,989	15,453,545	0	15,453,545	10,786,537	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	850,738,989	15,453,545	0	15,453,545	10,786,537	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	8,168,766	0				1.00	
2.00	Land Improvements	12,959,688	0				2.00	
3.00	Buildings and Fixtures	402,186,172	0				3.00	
4.00	Building Improvements	965,313	0				4.00	
5.00	Fixed Equipment	178,609,737	0				5.00	
6.00	Movable Equipment	252,516,321	0				6.00	
7.00	HIT designated Assets	0	0				7.00	
8.00	Subtotal (sum of lines 1-7)	855,405,997	0				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	855,405,997	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0239

Period:
From 07/01/2020
To 06/30/2021Worksheet A-7
Part II
Date/Time Prepared:
4/27/2022 12:54 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	0	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	0				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	0				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0239

Period:
From 07/01/2020
To 06/30/2021Worksheet A-7
Part III
Date/Time Prepared:
4/27/2022 12:54 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	602,889,676	0	602,889,676	0.704799	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	252,516,321	0	252,516,321	0.295201	0	2.00
3.00	Total (sum of lines 1-2)	855,405,997	0	855,405,997	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	31,223,410	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	31,223,410	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	583,799	0	0	583,799	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	31,223,410	2.00
3.00	Total (sum of lines 1-2)	0	583,799	0	0	31,807,209	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0239

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

Worksheet A-8

Date/Time Prepared:
4/27/2022 12:54 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Line #	Wkst. A-7 Ref.	
				Cost Center				
		1.00	2.00	3.00		4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)			0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)			0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)			0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)			0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)			0		0.00	0	7.00
8.00	Television and radio service (chapter 21)	A	-3,515		ADMINISTRATIVE & GENERAL	5.00	0	8.00
9.00	Parking lot (chapter 21)			0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-57,118,886				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	14,287,149				0	12.00
13.00	Laundry and linen service			0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-1,214,957		CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others			0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients			0		0.00	0	16.00
17.00	Sale of drugs to other than patients			0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-1,108		MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)			0		0.00	0	19.00
20.00	Vending machines	B	-8,314		CAFETERIA	11.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)			0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)			0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT			0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist			0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant			0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)			0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest			0		0.00	0	32.00
33.00	340B	A		1	DRUGS CHARGED TO PATIENTS	73.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0239

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

Worksheet A-8

Date/Time Prepared:
4/27/2022 12:54 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	
33.01	MISC REV - EMP BEN	B		0EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.01
33.02	MISC REV - ADMIN	B	-1,366,040	0ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	MISC REV - PLANT	B		0OPERATION OF PLANT	7.00	0	33.03
33.04	MISC REV	B		0SOCIAL SERVICE	17.00	0	33.04
33.05	MISC REV - PARAMED XRAY ED	B	-109,555	0PARAMEDICAL ED PROGRAM XRAY	23.00	0	33.05
33.06	MISC REV - PASTORAL ED	B		0PASTORAL EDUCATION PROGRAM	23.01	0	33.06
33.07	MISC REV - PARAMED EMT ED	B	-166,914	0PARAMED EDUC EMT PROGRAM	23.02	0	33.07
33.08	MISC REV - NICU	B	-5,180	0NEONATAL INTENSIVE CARE	34.01	0	33.08
33.09	MISC REV - XRAY	B	-22,253	0RADIOLOGY-DIAGNOSTIC	54.00	0	33.09
33.10	MISC REV - REF LAB	B	-3,011,677	0LABORATORY	60.00	0	33.10
33.11	MISC REV	B		0ELECTROCARDIOLOGY	69.00	0	33.11
33.12	MISC REV	B	-147,745	0EMERGENCY	91.00	0	33.12
33.14	MISC REVENUE	B	-1,014,798	0AMBULANCE SERVICES	95.00	0	33.14
33.16	MISC REV - PHARM	B		0PHARMACY	15.00	0	33.16
33.17	MISC REV	B		0OPERATING ROOM	50.00	0	33.17
33.18	MISC REV	B	-5,943	0RESPIRATORY THERAPY	65.00	0	33.18
33.19	MISC REV	B	-378	0CHILD PSYCHIATRIC CLINIC	90.03	0	33.19
34.01	INTEREST - ADMIN	A	-19,506,441	0ADMINISTRATIVE & GENERAL	5.00	0	34.01
34.02	INTEREST - SURG	A		0OPERATING ROOM	50.00	0	34.02
35.01	PATIENT PHONE - BLD & FIXT	A		0CAP REL COSTS-BLDG & FIXT	1.00	9	35.01
35.03	PATIENT PHONE - EMP BEN	A		0EMPLOYEE BENEFITS DEPARTMENT	4.00	0	35.03
35.04	PATIENT PHONE - ADMIN	A		0ADMINISTRATIVE & GENERAL	5.00	0	35.04
35.05	PATIENT PHONE - PLANT	A		0OPERATION OF PLANT	7.00	0	35.05
35.06	PATIENT PHONE - HOUSEKEEP	A		0HOUSEKEEPING	9.00	0	35.06
37.01	LOBBYING	A	-54,086	0ADMINISTRATIVE & GENERAL	5.00	0	37.01
39.01	TAXES - PROV ASSESS	A	-8,729,455	0ADMINISTRATIVE & GENERAL	5.00	0	39.01
41.02	PB TO CLINIC	A		0OPERATING ROOM	50.00	0	41.02
41.03	PB TO CLINIC	A		0GI LAB	76.00	0	41.03
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-78,200,095				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

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

Provider CCN: 14-0239

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

Worksheet A-8-1

Date/Time Prepared:

4/27/2022 12:54 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	COVID	698,138	0	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	MNGMT FEE & SHARED SVCS	30,142,100	28,117,784	2.00
3.00	14.00	CENTRAL SERVICES & SUPPLY	SUPPLY CHAIN	1,118,136	0	3.00
3.01	4.00	EMPLOYEE BENEFITS DEPARTMENT	EMPLOYEE BENEFIT	5,156,520	0	3.01
3.02	0.00			0	0	3.02
3.03	16.00	MEDICAL RECORDS & LIBRARY	MEDICAL RECORDS	1,674,226	0	3.03
3.04	90.06	HBP	CLINIC EXPENSE	277,376	0	3.04
3.05	90.07	MAIN	CLINIC EXPENSE	1,216,789	0	3.05
3.06	90.08	RMB	CLINIC EXPENSE	107,611	0	3.06
3.07	90.09	MULFORD	CLINIC EXPENSE	147,604	0	3.07
3.08	90.10	ALPINE	CLINIC EXPENSE	137,247	0	3.08
3.09	90.11	ROSCOE	CLINIC EXPENSE	119,631	0	3.09
3.10	90.12	BYRON	CLINIC EXPENSE	31,369	0	3.10
3.11	90.13	WINNEBAGO	CLINIC EXPENSE	111,982	0	3.11
3.12	90.14	PERRYVILLE	CLINIC EXPENSE	650,207	0	3.12
3.13	90.15	BELVIDERE	CLINIC EXPENSE	34,917	0	3.13
3.14	90.16	SPRINGBROOK	CLINIC EXPENSE	253,538	0	3.14
3.15	90.17	MCFARLAND	CLINIC EXPENSE	16,092	0	3.15
3.16	90.18	CHERRYVALLEY	CLINIC EXPENSE	58,625	0	3.16
3.18	90.20	GALLERIA	CLINIC EXPENSE	125,879	0	3.18
3.19	90.21	RIVERSIDE MOB	CLINIC EXPENSE	315,852	0	3.19
3.20	90.22	MULFORD-LENOX	CLINIC EXPENSE	11,094	0	3.20
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4).			42,404,933	28,117,784	5.00
	Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.					

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

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

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

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

6.00	B	MERCYHEALTH	100.00	MERCYHEALTH	100.00	6.00
7.00			0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

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

Provider CCN: 14-0239

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

Worksheet A-8-1

Date/Time Prepared:
4/27/2022 12:54 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	698,138	0		1.00
2.00	2,024,316	0		2.00
3.00	1,118,136	0		3.00
3.01	5,156,520	0		3.01
3.02	0	0		3.02
3.03	1,674,226	0		3.03
3.04	277,376	0		3.04
3.05	1,216,789	0		3.05
3.06	107,611	0		3.06
3.07	147,604	0		3.07
3.08	137,247	0		3.08
3.09	119,631	0		3.09
3.10	31,369	0		3.10
3.11	111,982	0		3.11
3.12	650,207	0		3.12
3.13	34,917	0		3.13
3.14	253,538	0		3.14
3.15	16,092	0		3.15
3.16	58,625	0		3.16
3.18	125,879	0		3.18
3.19	315,852	0		3.19
3.20	11,094	0		3.20
4.00	0	0		4.00
5.00	14,287,149			5.00

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

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

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0239

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

Worksheet A-8-2

Date/Time Prepared:
4/27/2022 12:54 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	0.00		0	0	0	0	0	1.00
2.00	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	51,322,682	51,307,682	15,000	211,500	464	2.00
3.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	1,328	1,328	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	34.01	AGGREGATE-NEONATAL INTENSIVE CARE	15,330	15,330	0	197,500	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	52.00	AGGREGATE-DELIVERY ROOM & LABOR ROOM	1,297,428	1,297,428	0	0	0	7.00
8.00	53.00	AGGREGATE-ANESTHESIOLOGY	1,703,118	1,703,118	0	239,400	0	8.00
9.00	66.00	AGGREGATE-PHYSICAL THERAPY	229	229	0	0	0	9.00
10.00	69.00	AGGREGATE-ELECTROCARDIOLOGY	173	173	0	0	0	10.00
11.00	90.01	AGGREGATE-PAIN CENTER	17,578	17,578	0	0	0	11.00
12.00	90.03	AGGREGATE-CHILD PSYCHIATRIC CLINIC	83,472	83,472	0	0	0	12.00
13.00	91.00	AGGREGATE-EMERGENCY	2,692,548	2,692,548	0	200,300	0	13.00
200.00			57,133,886	57,118,886	15,000		464	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	0.00		0	0	0	0	0	1.00
2.00	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	47,181	2,359	0	0	0	2.00
3.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	34.01	AGGREGATE-NEONATAL INTENSIVE CARE	0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	52.00	AGGREGATE-DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	7.00
8.00	53.00	AGGREGATE-ANESTHESIOLOGY	0	0	0	0	0	8.00
9.00	66.00	AGGREGATE-PHYSICAL THERAPY	0	0	0	0	0	9.00
10.00	69.00	AGGREGATE-ELECTROCARDIOLOGY	0	0	0	0	0	10.00
11.00	90.01	AGGREGATE-PAIN CENTER	0	0	0	0	0	11.00
12.00	90.03	AGGREGATE-CHILD PSYCHIATRIC CLINIC	0	0	0	0	0	12.00
13.00	91.00	AGGREGATE-EMERGENCY	0	0	0	0	0	13.00
200.00			47,181	2,359	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	0.00		0	0	0	0		1.00
2.00	5.00	AGGREGATE-ADMINISTRATIVE & GENERAL	0	47,181	0	51,307,682		2.00
3.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	0	0	1,328		3.00
4.00	0.00		0	0	0	0		4.00
5.00	34.01	AGGREGATE-NEONATAL INTENSIVE CARE	0	0	0	15,330		5.00
6.00	0.00		0	0	0	0		6.00
7.00	52.00	AGGREGATE-DELIVERY ROOM & LABOR ROOM	0	0	0	1,297,428		7.00
8.00	53.00	AGGREGATE-ANESTHESIOLOGY	0	0	0	1,703,118		8.00
9.00	66.00	AGGREGATE-PHYSICAL THERAPY	0	0	0	229		9.00
10.00	69.00	AGGREGATE-ELECTROCARDIOLOGY	0	0	0	173		10.00
11.00	90.01	AGGREGATE-PAIN CENTER	0	0	0	17,578		11.00
12.00	90.03	AGGREGATE-CHILD PSYCHIATRIC CLINIC	0	0	0	83,472		12.00
13.00	91.00	AGGREGATE-EMERGENCY	0	0	0	2,692,548		13.00
200.00			0	47,181	0	57,118,886		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0239

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part I
Date/Time Prepared:
4/27/2022 12:54 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	583,799				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	31,223,410	31,223,410			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	18,767,791	2,154	20,999	18,790,944	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	30,391,417	194,579	15,777,667	554,827	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	8,377,211	66,065	1,258,665	289,568	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,106,063	2,708	5,395	20,101	8.00
9.00	00900	HOUSEKEEPING	3,690,780	4,846	62,020	484,714	9.00
10.00	01000	DIETARY	1,390,024	10,274	52,156	168,519	10.00
11.00	01100	CAFETERIA	370,040	12,690	64,420	184,040	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	2,898,421	1,053	20,594	508,303	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,016,191	10,305	717,788	311,777	14.00
15.00	01500	PHARMACY	6,011,484	5,843	298,788	781,127	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,290,617	2,468	0	222,353	16.00
17.00	01700	SOCIAL SERVICE	86,776	943	0	15,436	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	3,036,483	0	0	592,418	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	4,463,496	1,559	9,161	593,882	22.00
23.00	02300	PARAMEDICAL ED PROGRAM XRAY	246,459	1,742	93	60,632	23.00
23.01	02301	PASTORAL EDUCATION PROGRAM	0	0	0	0	23.01
23.02	02302	PARAMED EDUC EMT PROGRAM	730,068	4,713	173,853	97,537	23.02
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	19,275,542	41,238	823,727	3,393,218	30.00
31.00	03100	INTENSIVE CARE UNIT	5,130,950	5,983	413,719	895,180	31.00
34.01	03401	NEONATAL INTENSIVE CARE	6,555,529	8,293	504,993	1,171,677	34.01
34.02	03402	PEDIATRIC INTENSIVE CARE	36,510	0	0	6,727	34.02
40.00	04000	SUBPROVIDER - IPF	239,665	790	81,567	43,336	40.00
43.00	04300	NURSERY	2,401,671	6,302	172,424	400,749	43.00
44.00	04400	SKILLED NURSING FACILITY	183,615	5,915	0	21,868	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	16,014,177	32,334	2,767,937	1,510,877	50.00
51.00	05100	RECOVERY ROOM	1,058,746	2,867	57,140	189,090	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,277,323	7,718	257,450	541,422	52.00
53.00	05300	ANESTHESIOLOGY	785,036	746	87,437	123,821	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,011,478	13,108	2,479,143	864,639	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,306,696	7,099	501,487	203,898	55.00
56.00	05600	RADIOISOTOPE	963,395	1,183	206,534	42,578	56.00
57.00	05700	CT SCAN	1,472,656	586	748,278	245,093	57.00
58.00	05800	MRI	816,027	3,156	801,151	139,223	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	10,793,191	12,221	579,828	789,995	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	378,325	0	1,715	64,340	64.00
65.00	06500	RESPIRATORY THERAPY	2,845,970	3,082	208,587	443,731	65.00
66.00	06600	PHYSICAL THERAPY	1,898,141	1,463	8,505	340,744	66.00
69.00	06900	ELECTROCARDIOLOGY	1,527,507	3,477	113,365	256,986	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	862,770	2,356	71,188	121,769	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	13,937,887	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	9,561,338	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	17,657,245	0	0	0	73.00
73.01	07301	INJECTABLE DRUGS	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	691,715	1,514	1,527	3,975	74.00
76.00	03340	GI LAB	1,389,276	6,538	845,877	203,509	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09003	PAIN CENTER	727,593	2,410	147,054	134,262	90.01
90.02	09001	ANTENATAL TEST CENTER	645,655	5,016	113,798	103,540	90.02
90.03	09002	CHILD PSYCHIATRIC CLINIC	33,358	47	2,099	21,000	90.03
90.04	09004	SPECIAL SURGICAL SERVICES	467,095	1,911	17,953	66,010	90.04
90.05	09005	GENETIC SERVICES	302,073	713	5,148	54,515	90.05
90.06	09006	HBP	277,376	0	0	0	90.06
90.07	09007	MAIN	1,216,789	0	0	0	90.07

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0239

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part I
Date/Time Prepared:
4/27/2022 12:54 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	
90.08	09008	RMB	107,611	0	0	0	107,611	90.08
90.09	09009	MULFORD	147,604	18,153	0	0	165,757	90.09
90.10	09010	ALPINE	137,247	9,192	0	0	146,439	90.10
90.11	09011	ROSCOE	119,631	13,667	0	0	133,298	90.11
90.12	09012	BYRON	31,369	3,621	0	0	34,990	90.12
90.13	09013	WINNEBAGO	111,982	4,258	0	0	116,240	90.13
90.14	09014	PERRYVILLE	650,207	0	0	0	650,207	90.14
90.15	09015	BELVIDERE	34,917	0	0	0	34,917	90.15
90.16	09016	SPRINGBROOK	253,538	0	0	0	253,538	90.16
90.17	09017	MCFARLAND	16,092	0	0	0	16,092	90.17
90.18	09018	CHERRYVALLEY	58,625	3,462	0	0	62,087	90.18
90.19	09019	KLECKNER	0	0	0	0	0	90.19
90.20	09020	GALLERIA	125,879	4,464	0	0	130,343	90.20
90.21	09021	RIVERSIDE MOB	315,852	0	0	0	315,852	90.21
90.22	09022	MULFORD-LENOX	11,094	0	0	0	11,094	90.22
91.00	09100	EMERGENCY	7,032,506	16,183	659,949	1,137,197	8,845,835	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	676,749	2,434	29,554	207,028	915,765	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	259,253,753	575,442	31,170,733	18,627,231	259,029,006	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.01	19301	BELOIT HEART STANDBY	22,537	0	0	4,156	26,693	193.01
194.00	07950	GUEST CENTER	219,392	0	20,796	0	240,188	194.00
194.01	07954	OTHER NONREIMBURSEABLE COST CENTER	64,078	368	13,577	11,224	89,247	194.01
194.02	07951	COMMUNITY SERVICES	644,553	2,112	5,680	31,863	684,208	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERSO	0	0	0	0	0	194.03
194.04	07952	AUXILIARY	145,408	5,138	7,473	13,143	171,162	194.04
194.05	07956	RETAIL PHARMACY	10,091,345	739	5,151	103,327	10,200,562	194.05
194.08	07955	DIALYSIS RENTED SPACE	0	0	0	0	0	194.08
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	270,441,066	583,799	31,223,410	18,790,944	270,441,066	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0239

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part I
Date/Time Prepared:
4/27/2022 12:54 pm

Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	46,918,490					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	2,097,268	0	12,088,777			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	238,088	0	103,890	1,476,245		8.00
9.00	00900	HOUSEKEEPING	890,493	0	185,937	0	5,318,790	9.00
10.00	01000	DIETARY	340,250	0	394,183	0	217,961	10.00
11.00	01100	CAFETERIA	132,490	0	486,869	0	269,210	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	719,632	0	40,391	0	22,334	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	851,387	0	395,366	132,101	218,614	14.00
15.00	01500	PHARMACY	1,489,747	0	224,180	0	123,958	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	737,908	0	94,683	0	52,354	16.00
17.00	01700	SOCIAL SERVICE	21,653	0	36,162	0	19,995	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	761,724	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	1,063,819	0	59,803	0	33,068	22.00
23.00	02300	PARAMEDICAL ED PROGRAM XRAY	64,845	0	66,829	0	36,953	23.00
23.01	02301	PASTORAL EDUCATION PROGRAM	0	0	0	0	0	23.01
23.02	02302	PARAMED EDUC EMT PROGRAM	211,200	0	180,809	0	99,977	23.02
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,939,831	0	1,582,147	382,193	874,836	30.00
31.00	03100	INTENSIVE CARE UNIT	1,353,012	0	229,557	130,571	126,932	31.00
34.01	03401	NEONATAL INTENSIVE CARE	1,729,720	0	318,180	47,798	175,935	34.01
34.02	03402	PEDIATRIC INTENSIVE CARE	9,076	0	0	0	0	34.02
40.00	04000	SUBPROVIDER - IPF	76,690	0	30,318	294	16,764	40.00
43.00	04300	NURSERY	625,757	0	241,778	42,269	133,689	43.00
44.00	04400	SKILLED NURSING FACILITY	44,373	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	4,266,387	0	1,240,539	264,592	685,947	50.00
51.00	05100	RECOVERY ROOM	274,523	0	110,000	18,079	60,824	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	857,234	0	296,120	96,242	163,738	52.00
53.00	05300	ANESTHESIOLOGY	209,284	0	28,603	0	15,816	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,756,562	0	502,902	87,395	278,076	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	423,836	0	272,379	13,836	150,610	55.00
56.00	05600	RADIOISOTOPE	254,760	0	45,385	939	25,095	56.00
57.00	05700	CT SCAN	517,754	0	22,493	0	12,437	57.00
58.00	05800	MRI	369,340	0	121,089	7,229	66,955	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	2,555,643	0	468,888	13,219	259,268	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	93,278	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	734,955	0	118,258	101	65,390	65.00
66.00	06600	PHYSICAL THERAPY	472,045	0	56,141	329	31,043	66.00
69.00	06900	ELECTROCARDIOLOGY	399,100	0	133,392	4,519	73,758	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	222,097	0	90,388	30	49,979	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,925,632	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,006,973	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,706,344	0	0	0	0	73.00
73.01	07301	INJECTABLE DRUGS	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	146,667	0	58,072	2,439	32,110	74.00
76.00	03340	GI LAB	513,260	0	250,852	23,898	138,706	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09003	PAIN CENTER	212,281	0	92,452	13,014	51,121	90.01
90.02	09001	ANTENATAL TEST CENTER	182,199	0	192,463	274	106,421	90.02
90.03	09002	CHILD PSYCHIATRIC CLINIC	11,860	0	1,815	0	1,003	90.03
90.04	09004	SPECIAL SURGICAL SERVICES	116,071	0	73,323	0	40,543	90.04
90.05	09005	GENETIC SERVICES	76,080	0	27,338	0	15,116	90.05
90.06	09006	HBP	58,223	0	0	0	0	90.06
90.07	09007	MAIN	255,410	0	0	0	0	90.07
90.08	09008	RMB	22,588	0	0	0	0	90.08
90.09	09009	MULFORD	34,793	0	696,481	0	0	90.09
90.10	09010	ALPINE	30,738	0	352,677	0	0	90.10
90.11	09011	ROSCOE	27,980	0	524,346	0	0	90.11
90.12	09012	BYRON	7,345	0	138,920	0	0	90.12

COST ALLOCATION - GENERAL SERVICE COSTS

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Period:
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Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
90.13	09013	WINNEBAGO	24,399	0	163,377	0	0	90.13
90.14	09014	PERRYVILLE	136,482	0	0	0	0	90.14
90.15	09015	BELVIDERE	7,329	0	0	0	0	90.15
90.16	09016	SPRINGBROOK	53,219	0	0	0	0	90.16
90.17	09017	MCFARLAND	3,378	0	0	0	0	90.17
90.18	09018	CHERRYVALLEY	13,032	0	132,810	0	0	90.18
90.19	09019	KLECKNER	0	0	0	0	0	90.19
90.20	09020	GALLERIA	27,360	0	171,269	0	0	90.20
90.21	09021	RIVERSIDE MOB	66,299	0	0	0	0	90.21
90.22	09022	MULFORD-LENOX	2,329	0	0	0	0	90.22
91.00	09100	EMERGENCY	1,856,785	0	620,877	194,385	343,309	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92.00
95.00	09500	AMBULANCE SERVICES	192,224	0	93,401	499	51,646	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	44,523,041	0	11,768,132	1,476,245	5,141,491	118.00
		NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.01	19301	BELOIT HEART STANDBY	5,603	0	0	0	0	193.01
194.00	07950	GUEST CENTER	50,417	0	0	0	0	194.00
194.01	07954	OTHER NONREIMBURSEABLE COST CENTER	18,733	0	14,118	0	7,807	194.01
194.02	07951	COMMUNITY SERVICES	143,619	0	81,048	0	44,815	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERSO	0	0	0	0	0	194.03
194.04	07952	AUXILIARY	35,928	0	197,142	0	109,008	194.04
194.05	07956	RETAIL PHARMACY	2,141,149	0	28,337	0	15,669	194.05
194.08	07955	DIALYSIS RENTED SPACE	0	0	0	0	0	194.08
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	46,918,490	0	12,088,777	1,476,245	5,318,790	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	2,573,367					10.00
11.00	01100	CAFETERIA	0	1,519,759				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	40,884	0	4,251,612		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	50,575	0	0	5,704,104	14.00
15.00	01500	PHARMACY	0	51,628	0	0	2,939	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	24,424	0	33,675	0	16.00
17.00	01700	SOCIAL SERVICE	0	2,261	0	228	4	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	65,113	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	11,809	0	0	0	22.00
23.00	02300	PARAMDICAL ED PROGRAM XRAY	0	4,105	0	0	0	23.00
23.01	02301	PASTORAL EDUCATION PROGRAM	0	0	0	0	0	23.01
23.02	02302	PARAMED EDUC EMT PROGRAM	0	10,146	0	146	132	23.02
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,193,509	344,116	0	1,342,249	294	30.00
31.00	03100	INTENSIVE CARE UNIT	370,902	75,974	0	392,541	0	31.00
34.01	03401	NEONATAL INTENSIVE CARE	0	99,969	0	562,683	697	34.01
34.02	03402	PEDIATRIC INTENSIVE CARE	0	0	0	0	0	34.02
40.00	04000	SUBPROVIDER - IPF	0	4,235	0	2,968	0	40.00
43.00	04300	NURSERY	0	35,583	0	203,890	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	1,728	0	4,147	410	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	119,079	0	495,848	837,523	50.00
51.00	05100	RECOVERY ROOM	0	14,576	0	86,331	217	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	44,015	0	243,242	0	52.00
53.00	05300	ANESTHESIOLOGY	0	10,380	0	48,813	191	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	81,274	0	104,873	1,683	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	15,772	0	45,414	1,048	55.00
56.00	05600	RADIOISOTOPE	0	3,469	0	264	57,964	56.00
57.00	05700	CT SCAN	0	22,683	0	2,712	0	57.00
58.00	05800	MRI	0	9,886	0	1,529	4,915	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	80,716	0	0	873,802	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	5,963	0	21,404	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	39,429	0	1,037	48	65.00
66.00	06600	PHYSICAL THERAPY	0	26,879	0	0	334	66.00
69.00	06900	ELECTROCARDIOLOGY	0	22,189	0	47,012	570	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	11,640	0	0	12,089	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	2,309,745	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1,584,512	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	INJECTABLE DRUGS	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	247	0	569	1,703	74.00
76.00	03340	GI LAB	0	18,941	0	69,209	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPS	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09003	PAIN CENTER	0	11,380	0	52,005	0	90.01
90.02	09001	ANTENATAL TEST CENTER	0	9,809	0	19,245	2,083	90.02
90.03	09002	CHILD PSYCHIATRIC CLINIC	0	663	0	0	5	90.03
90.04	09004	SPECIAL SURGICAL SERVICES	0	5,145	0	31,423	0	90.04
90.05	09005	GENETIC SERVICES	0	4,755	0	216	18	90.05
90.06	09006	HBP	0	0	0	0	0	90.06
90.07	09007	MAIN	0	0	0	0	0	90.07
90.08	09008	RMB	0	0	0	0	0	90.08
90.09	09009	MULFORD	0	0	0	0	0	90.09
90.10	09010	ALPINE	0	0	0	0	0	90.10
90.11	09011	ROSCOE	0	0	0	0	0	90.11

COST ALLOCATION - GENERAL SERVICE COSTS

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Period:
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Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
90.12	09012	BYRON	0	0	0	0	0	90.12
90.13	09013	WINNEBAGO	0	0	0	0	0	90.13
90.14	09014	PERRYVILLE	0	0	0	0	0	90.14
90.15	09015	BELVIDERE	0	0	0	0	0	90.15
90.16	09016	SPRINGBROOK	0	0	0	0	0	90.16
90.17	09017	MCFARLAND	0	0	0	0	0	90.17
90.18	09018	CHERRYVALLEY	0	0	0	0	0	90.18
90.19	09019	KLECKNER	0	0	0	0	0	90.19
90.20	09020	GALLERIA	0	0	0	0	0	90.20
90.21	09021	RIVERSIDE MOB	0	0	0	0	0	90.21
90.22	09022	MULFORD-LENOX	0	0	0	0	0	90.22
91.00	09100	EMERGENCY	8,956	111,362	0	394,188	4	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	14,161	0	37,493	6,179	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,573,367	1,506,963	0	4,245,354	5,699,109	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.01	19301	BELOIT HEART STANDBY	0	104	0	0	0	193.01
194.00	07950	GUEST CENTER	0	0	0	0	0	194.00
194.01	07954	OTHER NONREIMBURSEABLE COST CENTER	0	1,078	0	0	0	194.01
194.02	07951	COMMUNITY SERVICES	0	961	0	6,258	119	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERSO	0	0	0	0	0	194.03
194.04	07952	AUXILIARY	0	1,637	0	0	4,821	194.04
194.05	07956	RETAIL PHARMACY	0	9,016	0	0	55	194.05
194.08	07955	DIALYSIS RENTED SPACE	0	0	0	0	0	194.08
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,573,367	1,519,759	0	4,251,612	5,704,104	202.00

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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING PROGRAM	
			15.00	16.00	17.00	19.00	20.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	8,989,694					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	4,458,482				16.00
17.00	01700	SOCIAL SERVICE	0	0	183,458			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
20.00	02000	NURSING PROGRAM	0	0	0		0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0			22.00
23.00	02300	PARAMDICAL ED PROGRAM XRAY	0	0	0			23.00
23.01	02301	PASTORAL EDUCATION PROGRAM	0	0	0			23.01
23.02	02302	PARAMED EDUC EMT PROGRAM	24,442	0	0			23.02
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	78,791	171,547	156,248	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	29,409	94,758	0	0	0	31.00
34.01	03401	NEONATAL INTENSIVE CARE	9,264	212,949	2,393	0	0	34.01
34.02	03402	PEDIATRIC INTENSIVE CARE	60	0	680	0	0	34.02
40.00	04000	SUBPROVIDER - IPF	0	445	22,800	0	0	40.00
43.00	04300	NURSERY	0	23,602	1,337	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	17	446	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	56,693	285,356	0	0	0	50.00
51.00	05100	RECOVERY ROOM	4,743	26,577	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	11,498	59,708	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	28,483	55,020	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	25,353	307,130	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	5,073	61,402	0	0	0	55.00
56.00	05600	RADIOISOTOPE	2,233	55,011	0	0	0	56.00
57.00	05700	CT SCAN	20,720	323,122	0	0	0	57.00
58.00	05800	MRI	2,755	109,994	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	140	480,692	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	4,336	92,131	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	352	100,677	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	42,877	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	24,227	125,061	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	157	29,923	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	461,171	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	286,233	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,623,590	685,024	0	0	0	73.00
73.01	07301	INJECTABLE DRUGS	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	341	5,425	0	0	0	74.00
76.00	03340	GI LAB	7,156	44,724	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPS	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09003	PAIN CENTER	2,902	35,292	0	0	0	90.01
90.02	09001	ANTENATAL TEST CENTER	1,340	36,636	0	0	0	90.02
90.03	09002	CHILD PSYCHIATRIC CLINIC	0	333	0	0	0	90.03
90.04	09004	SPECIAL SURGICAL SERVICES	16,316	8,694	0	0	0	90.04
90.05	09005	GENETIC SERVICES	0	779	0	0	0	90.05
90.06	09006	HBP	0	1,685	0	0	0	90.06
90.07	09007	MAIN	0	9,325	0	0	0	90.07
90.08	09008	RMB	0	1,122	0	0	0	90.08
90.09	09009	MULFORD	0	1,493	0	0	0	90.09
90.10	09010	ALPINE	0	1,631	0	0	0	90.10
90.11	09011	ROSCOE	0	1,613	0	0	0	90.11

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0239

Period:
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To 06/30/2021Worksheet B
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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING PROGRAM	
			15.00	16.00	17.00	19.00	20.00	
90.12	09012	BYRON	0	287	0	0	0	90.12
90.13	09013	WINNEBAGO	0	970	0	0	0	90.13
90.14	09014	PERRYVILLE	0	8,325	0	0	0	90.14
90.15	09015	BELVIDERE	0	248	0	0	0	90.15
90.16	09016	SPRINGBROOK	0	3,310	0	0	0	90.16
90.17	09017	MCFARLAND	0	136	0	0	0	90.17
90.18	09018	CHERRYVALLEY	0	622	0	0	0	90.18
90.19	09019	KLECKNER	0	0	0	0	0	90.19
90.20	09020	GALLERIA	0	2,465	0	0	0	90.20
90.21	09021	RIVERSIDE MOB	0	2,128	0	0	0	90.21
90.22	09022	MULFORD-LENOX	0	84	0	0	0	90.22
91.00	09100	EMERGENCY	98,271	200,299	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	1,320	0	0	0	0	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	6,079,982	4,458,482	183,458	0	0	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.01	19301	BELOIT HEART STANDBY	0	0	0	0	0	193.01
194.00	07950	GUEST CENTER	0	0	0	0	0	194.00
194.01	07954	OTHER NONREIMBURSEABLE COST CENTER	0	0	0	0	0	194.01
194.02	07951	COMMUNITY SERVICES	210	0	0	0	0	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERSO	0	0	0	0	0	194.03
194.04	07952	AUXILIARY	0	0	0	0	0	194.04
194.05	07956	RETAIL PHARMACY	2,909,502	0	0	0	0	194.05
194.08	07955	DIALYSIS RENTED SPACE	0	0	0	0	0	194.08
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	8,989,694	4,458,482	183,458	0	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0239

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part I
Date/Time Prepared:
4/27/2022 12:54 pm

Cost Center Description			INTERNS & RESIDENTS		PARAMDICAL ED PROGRAM XRAY	PASTORAL EDUCATION PROGRAM	PARAMED EDUC EMT PROGRAM	
			SERVICES-SALAR Y & FRINGES	SERVICES-OTHER PRGM COSTS				
			APPRV	APPRV				
			21.00	22.00	23.00	23.01	23.02	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
20.00	02000	NURSING PROGRAM						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	4,455,738					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		6,236,597				22.00
23.00	02300	PARAMDICAL ED PROGRAM XRAY			481,658			23.00
23.01	02301	PASTORAL EDUCATION PROGRAM				0		23.01
23.02	02302	PARAMED EDUC EMT PROGRAM					1,533,023	23.02
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	4,455,738	6,236,597	0	0	40,721	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
34.01	03401	NEONATAL INTENSIVE CARE	0	0	0	0	81,442	34.01
34.02	03402	PEDIATRIC INTENSIVE CARE	0	0	0	0	0	34.02
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	213,186	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	40,721	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	481,658	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	31,140	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	INJECTABLE DRUGS	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03340	GI LAB	0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09003	PAIN CENTER	0	0	0	0	0	90.01
90.02	09001	ANTENATAL TEST CENTER	0	0	0	0	0	90.02
90.03	09002	CHILD PSYCHIATRIC CLINIC	0	0	0	0	0	90.03
90.04	09004	SPECIAL SURGICAL SERVICES	0	0	0	0	0	90.04
90.05	09005	GENETIC SERVICES	0	0	0	0	0	90.05
90.06	09006	HBP	0	0	0	0	0	90.06
90.07	09007	MAIN	0	0	0	0	0	90.07
90.08	09008	RMB	0	0	0	0	0	90.08
90.09	09009	MULFORD	0	0	0	0	0	90.09

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0239

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part I
Date/Time Prepared:
4/27/2022 12:54 pm

Cost Center Description			INTERNS & RESIDENTS		PARAMDICAL ED PROGRAM XRAY	PASTORAL EDUCATION PROGRAM	PARAMED EDUC EMT PROGRAM	
			SERVICES-SALAR Y & FRINGES	SERVICES-OTHER PRGM COSTS				
			APPRV	APPRV				
			21.00	22.00	23.00	23.01	23.02	
90.10	09010	ALPINE	0	0	0	0	0	90.10
90.11	09011	ROSCOE	0	0	0	0	0	90.11
90.12	09012	BYRON	0	0	0	0	0	90.12
90.13	09013	WINNEBAGO	0	0	0	0	0	90.13
90.14	09014	PERRYVILLE	0	0	0	0	0	90.14
90.15	09015	BELVIDERE	0	0	0	0	0	90.15
90.16	09016	SPRINGBROOK	0	0	0	0	0	90.16
90.17	09017	MCFARLAND	0	0	0	0	0	90.17
90.18	09018	CHERRYVALLEY	0	0	0	0	0	90.18
90.19	09019	KLECKNER	0	0	0	0	0	90.19
90.20	09020	GALLERIA	0	0	0	0	0	90.20
90.21	09021	RIVERSIDE MOB	0	0	0	0	0	90.21
90.22	09022	MULFORD-LENOX	0	0	0	0	0	90.22
91.00	09100	EMERGENCY	0	0	0	0	1,125,813	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,455,738	6,236,597	481,658	0	1,533,023	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.01	19301	BELOIT HEART STANDBY	0	0	0	0	0	193.01
194.00	07950	GUEST CENTER	0	0	0	0	0	194.00
194.01	07954	OTHER NONREIMBURSEABLE COST CENTER	0	0	0	0	0	194.01
194.02	07951	COMMUNITY SERVICES	0	0	0	0	0	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERSO	0	0	0	0	0	194.03
194.04	07952	AUXILIARY	0	0	0	0	0	194.04
194.05	07956	RETAIL PHARMACY	0	0	0	0	0	194.05
194.08	07955	DIALYSIS RENTED SPACE	0	0	0	0	0	194.08
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	4,455,738	6,236,597	481,658	0	1,533,023	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0239

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part I
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Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
6.00	00600	MAINTENANCE & REPAIRS				6.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
12.00	01200	MAINTENANCE OF PERSONNEL				12.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS				19.00
20.00	02000	NURSING PROGRAM				20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV				22.00
23.00	02300	PARAMDICAL ED PROGRAM XRAY				23.00
23.01	02301	PASTORAL EDUCATION PROGRAM				23.01
23.02	02302	PARAMED EDUC EMT PROGRAM				23.02
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	46,332,542	-10,692,335	35,640,207	30.00
31.00	03100	INTENSIVE CARE UNIT	9,249,488	0	9,249,488	31.00
34.01	03401	NEONATAL INTENSIVE CARE	11,481,522	0	11,481,522	34.01
34.02	03402	PEDIATRIC INTENSIVE CARE	53,053	0	53,053	34.02
40.00	04000	SUBPROVIDER - IPF	519,872	0	519,872	40.00
43.00	04300	NURSERY	4,289,051	0	4,289,051	43.00
44.00	04400	SKILLED NURSING FACILITY	262,519	0	262,519	44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	28,790,475	0	28,790,475	50.00
51.00	05100	RECOVERY ROOM	1,903,713	0	1,903,713	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,896,431	0	5,896,431	52.00
53.00	05300	ANESTHESIOLOGY	1,393,630	0	1,393,630	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,995,274	0	11,995,274	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	3,008,550	0	3,008,550	55.00
56.00	05600	RADIOISOTOPE	1,658,810	0	1,658,810	56.00
57.00	05700	CT SCAN	3,388,534	0	3,388,534	57.00
58.00	05800	MRI	2,453,249	0	2,453,249	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000	LABORATORY	16,907,603	0	16,907,603	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	661,492	0	661,492	64.00
65.00	06500	RESPIRATORY THERAPY	4,592,757	0	4,592,757	65.00
66.00	06600	PHYSICAL THERAPY	2,878,501	0	2,878,501	66.00
69.00	06900	ELECTROCARDIOLOGY	2,731,163	0	2,731,163	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,474,386	0	1,474,386	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	19,634,435	0	19,634,435	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,439,056	0	13,439,056	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	27,672,203	0	27,672,203	73.00
73.01	07301	INJECTABLE DRUGS	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	946,304	0	946,304	74.00
76.00	03340	GI LAB	3,511,946	0	3,511,946	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	76.98
76.99	07699	LITHOTRIPS	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	90.00
90.01	09003	PAIN CENTER	1,481,766	0	1,481,766	90.01
90.02	09001	ANTENATAL TEST CENTER	1,418,479	0	1,418,479	90.02
90.03	09002	CHLD PSYCHIATRIC CLINIC	72,183	0	72,183	90.03
90.04	09004	SPECIAL SURGICAL SERVICES	844,484	0	844,484	90.04
90.05	09005	GENETIC SERVICES	486,751	0	486,751	90.05
90.06	09006	HBP	337,284	0	337,284	90.06
90.07	09007	MAIN	1,481,524	0	1,481,524	90.07
90.08	09008	RMB	131,321	0	131,321	90.08
90.09	09009	MULFORD	898,524	0	898,524	90.09

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0239

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part I
Date/Time Prepared:
4/27/2022 12:54 pm

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
90.10	09010	ALPINE	531,485	0	531,485	90.10
90.11	09011	ROSCOE	687,237	0	687,237	90.11
90.12	09012	BYRON	181,542	0	181,542	90.12
90.13	09013	WINNEBAGO	304,986	0	304,986	90.13
90.14	09014	PERRYVILLE	795,014	0	795,014	90.14
90.15	09015	BELVIDERE	42,494	0	42,494	90.15
90.16	09016	SPRINGBROOK	310,067	0	310,067	90.16
90.17	09017	MCFARLAND	19,606	0	19,606	90.17
90.18	09018	CHERRYVALLEY	208,551	0	208,551	90.18
90.19	09019	KLECKNER	0	0	0	90.19
90.20	09020	GALLERIA	331,437	0	331,437	90.20
90.21	09021	RIVERSIDE MOB	384,279	0	384,279	90.21
90.22	09022	MULFORD-LENOX	13,507	0	13,507	90.22
91.00	09100	EMERGENCY	13,800,084	0	13,800,084	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0		92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,312,688	0	1,312,688	95.00
99.10	09910	CORF	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	253,201,852	-10,692,335	242,509,517	118.00
NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	192.00
193.01	19301	BELOIT HEART STANDBY	32,400	0	32,400	193.01
194.00	07950	GUEST CENTER	290,605	0	290,605	194.00
194.01	07954	OTHER NONREIMBURSEABLE COST CENTER	130,983	0	130,983	194.01
194.02	07951	COMMUNITY SERVICES	961,238	0	961,238	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERSO	0	0	0	194.03
194.04	07952	AUXILIARY	519,698	0	519,698	194.04
194.05	07956	RETAIL PHARMACY	15,304,290	0	15,304,290	194.05
194.08	07955	DIALYSIS RENTED SPACE	0	0	0	194.08
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	270,441,066	-10,692,335	259,748,731	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0239

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
Date/Time Prepared:
4/27/2022 12:54 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	2,154	20,999	23,153	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	788,907	194,579	15,777,667	16,761,153	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	4,325	66,065	1,258,665	1,329,055	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	2,708	5,395	8,103	8.00
9.00	00900	HOUSEKEEPING	0	4,846	62,020	66,866	9.00
10.00	01000	DIETARY	0	10,274	52,156	62,430	10.00
11.00	01100	CAFETERIA	0	12,690	64,420	77,110	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	1,053	20,594	21,647	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	361,926	10,305	717,788	1,090,019	14.00
15.00	01500	PHARMACY	1,221,597	5,843	298,788	1,526,228	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,468	0	2,468	16.00
17.00	01700	SOCIAL SERVICE	0	943	0	943	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	1,559	9,161	10,720	22.00
23.00	02300	PARAMDICAL ED PROGRAM XRAY	0	1,742	93	1,835	23.00
23.01	02301	PASTORAL EDUCATION PROGRAM	0	0	0	0	23.01
23.02	02302	PARAMED EDUC EMT PROGRAM	9,000	4,713	173,853	187,566	23.02
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	41,238	823,727	864,965	30.00
31.00	03100	INTENSIVE CARE UNIT	0	5,983	413,719	419,702	31.00
34.01	03401	NEONATAL INTENSIVE CARE	0	8,293	504,993	513,286	34.01
34.02	03402	PEDIATRIC INTENSIVE CARE	0	0	0	0	34.02
40.00	04000	SUBPROVIDER - IPF	0	790	81,567	82,357	40.00
43.00	04300	NURSERY	0	6,302	172,424	178,726	43.00
44.00	04400	SKILLED NURSING FACILITY	0	5,915	0	5,915	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	32,334	2,767,937	2,800,271	50.00
51.00	05100	RECOVERY ROOM	0	2,867	57,140	60,007	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	10,350	7,718	257,450	275,518	52.00
53.00	05300	ANESTHESIOLOGY	0	746	87,437	88,183	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,600	13,108	2,479,143	2,494,851	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	3,975	7,099	501,487	512,561	55.00
56.00	05600	RADIOISOTOPE	0	1,183	206,534	207,717	56.00
57.00	05700	CT SCAN	0	586	748,278	748,864	57.00
58.00	05800	MRI	0	3,156	801,151	804,307	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	60,219	12,221	579,828	652,268	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	1,715	1,715	64.00
65.00	06500	RESPIRATORY THERAPY	22,288	3,082	208,587	233,957	65.00
66.00	06600	PHYSICAL THERAPY	0	1,463	8,505	9,968	66.00
69.00	06900	ELECTROCARDIOLOGY	0	3,477	113,365	116,842	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	101,045	2,356	71,188	174,589	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
73.01	07301	INJECTABLE DRUGS	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	1,514	1,527	3,041	74.00
76.00	03340	GI LAB	227,658	6,538	845,877	1,080,073	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09003	PAIN CENTER	0	2,410	147,054	149,464	90.01
90.02	09001	ANTENATAL TEST CENTER	0	5,016	113,798	118,814	90.02
90.03	09002	CHILD PSYCHIATRIC CLINIC	0	47	2,099	2,146	90.03
90.04	09004	SPECIAL SURGICAL SERVICES	52,884	1,911	17,953	72,748	90.04
90.05	09005	GENETIC SERVICES	0	713	5,148	5,861	90.05
90.06	09006	HBP	0	0	0	0	90.06
90.07	09007	MAIN	0	0	0	0	90.07
90.08	09008	RMB	0	0	0	0	90.08

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0239

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
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Cost Center Description			Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
				BLDG & FIXT	MVBLE EQUIP			
				1.00	2.00	2A	4.00	
90.09	09009	MULFORD	0	18,153	0	18,153	0	90.09
90.10	09010	ALPINE	0	9,192	0	9,192	0	90.10
90.11	09011	ROSCOE	0	13,667	0	13,667	0	90.11
90.12	09012	BYRON	0	3,621	0	3,621	0	90.12
90.13	09013	WINNEBAGO	0	4,258	0	4,258	0	90.13
90.14	09014	PERRYVILLE	0	0	0	0	0	90.14
90.15	09015	BELVIDERE	0	0	0	0	0	90.15
90.16	09016	SPRINGBROOK	0	0	0	0	0	90.16
90.17	09017	MCFARLAND	0	0	0	0	0	90.17
90.18	09018	CHERRYVALLEY	0	3,462	0	3,462	0	90.18
90.19	09019	KLECKNER	0	0	0	0	0	90.19
90.20	09020	GALLERIA	0	4,464	0	4,464	0	90.20
90.21	09021	RIVERSIDE MOB	0	0	0	0	0	90.21
90.22	09022	MULFORD-LENOX	0	0	0	0	0	90.22
91.00	09100	EMERGENCY	0	16,183	659,949	676,132	1,399	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	2,434	29,554	31,988	255	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,866,774	575,442	31,170,733	34,612,949	22,952	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.01	19301	BELOIT HEART STANDBY	0	0	0	0	5	193.01
194.00	07950	GUEST CENTER	0	0	20,796	20,796	0	194.00
194.01	07954	OTHER NONREIMBURSEABLE COST CENTER	0	368	13,577	13,945	14	194.01
194.02	07951	COMMUNITY SERVICES	0	2,112	5,680	7,792	39	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERSO	0	0	0	0	0	194.03
194.04	07952	AUXILIARY	0	5,138	7,473	12,611	16	194.04
194.05	07956	RETAIL PHARMACY	0	739	5,151	5,890	127	194.05
194.08	07955	DIALYSIS RENTED SPACE	0	0	0	0	0	194.08
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,866,774	583,799	31,223,410	34,673,983	23,153	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0239

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	16,761,836					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	749,253	0	2,078,664			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	85,058	0	17,864	111,050		8.00
9.00	00900	HOUSEKEEPING	318,130	0	31,972	0	417,564	9.00
10.00	01000	DIETARY	121,555	0	67,780	0	17,112	10.00
11.00	01100	CAFETERIA	47,332	0	83,717	0	21,135	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	257,090	0	6,945	0	1,753	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	304,160	0	67,983	9,937	17,163	14.00
15.00	01500	PHARMACY	532,215	0	38,548	0	9,732	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	263,619	0	16,281	0	4,110	16.00
17.00	01700	SOCIAL SERVICE	7,735	0	6,218	0	1,570	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	272,128	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	380,052	0	10,283	0	2,596	22.00
23.00	02300	PARAMEDICAL ED PROGRAM XRAY	23,166	0	11,491	0	2,901	23.00
23.01	02301	PASTORAL EDUCATION PROGRAM	0	0	0	0	0	23.01
23.02	02302	PARAMED EDUC EMT PROGRAM	75,452	0	31,090	0	7,849	23.02
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,764,873	0	272,049	28,749	68,680	30.00
31.00	03100	INTENSIVE CARE UNIT	483,366	0	39,472	9,822	9,965	31.00
34.01	03401	NEONATAL INTENSIVE CARE	617,946	0	54,711	3,596	13,812	34.01
34.02	03402	PEDIATRIC INTENSIVE CARE	3,242	0	0	0	0	34.02
40.00	04000	SUBPROVIDER - IPF	27,398	0	5,213	22	1,316	40.00
43.00	04300	NURSERY	223,553	0	41,574	3,180	10,496	43.00
44.00	04400	SKILLED NURSING FACILITY	15,853	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,524,176	0	213,311	19,904	53,852	50.00
51.00	05100	RECOVERY ROOM	98,074	0	18,915	1,360	4,775	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	306,249	0	50,918	7,240	12,855	52.00
53.00	05300	ANESTHESIOLOGY	74,767	0	4,918	0	1,242	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	627,536	0	86,474	6,574	21,831	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	151,416	0	46,836	1,041	11,824	55.00
56.00	05600	RADIOISOTOPE	91,013	0	7,804	71	1,970	56.00
57.00	05700	CT SCAN	184,969	0	3,868	0	976	57.00
58.00	05800	MRI	131,947	0	20,821	544	5,256	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	913,009	0	80,625	994	20,354	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	33,324	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	262,564	0	20,335	8	5,134	65.00
66.00	06600	PHYSICAL THERAPY	168,639	0	9,653	25	2,437	66.00
69.00	06900	ELECTROCARDIOLOGY	142,579	0	22,937	340	5,791	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	79,345	0	15,542	2	3,924	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,045,188	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	716,995	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,324,099	0	0	0	0	73.00
73.01	07301	INJECTABLE DRUGS	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	52,397	0	9,985	183	2,521	74.00
76.00	03340	GI LAB	183,363	0	43,134	1,798	10,889	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09003	PAIN CENTER	75,838	0	15,897	979	4,013	90.01
90.02	09001	ANTENATAL TEST CENTER	65,091	0	33,094	21	8,355	90.02
90.03	09002	CHILD PSYCHIATRIC CLINIC	4,237	0	312	0	79	90.03
90.04	09004	SPECIAL SURGICAL SERVICES	41,467	0	12,608	0	3,183	90.04
90.05	09005	GENETIC SERVICES	27,180	0	4,701	0	1,187	90.05
90.06	09006	HBP	20,800	0	0	0	0	90.06
90.07	09007	MAIN	91,246	0	0	0	0	90.07
90.08	09008	RMB	8,070	0	0	0	0	90.08
90.09	09009	MULFORD	12,430	0	119,760	0	0	90.09
90.10	09010	ALPINE	10,981	0	60,643	0	0	90.10
90.11	09011	ROSCOE	9,996	0	90,161	0	0	90.11
90.12	09012	BYRON	2,624	0	23,887	0	0	90.12

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0239

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
90.13	09013	WINNEBAGO	8,717	0	28,093	0	0	90.13
90.14	09014	PERRYVILLE	48,758	0	0	0	0	90.14
90.15	09015	BELVIDERE	2,618	0	0	0	0	90.15
90.16	09016	SPRINGBROOK	19,013	0	0	0	0	90.16
90.17	09017	MCFARLAND	1,207	0	0	0	0	90.17
90.18	09018	CHERRYVALLEY	4,656	0	22,837	0	0	90.18
90.19	09019	KLECKNER	0	0	0	0	0	90.19
90.20	09020	GALLERIA	9,774	0	29,450	0	0	90.20
90.21	09021	RIVERSIDE MOB	23,685	0	0	0	0	90.21
90.22	09022	MULFORD-LENOX	832	0	0	0	0	90.22
91.00	09100	EMERGENCY	663,340	0	106,760	14,622	26,952	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92.00
95.00	09500	AMBULANCE SERVICES	68,672	0	16,060	38	4,055	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	15,906,057	0	2,023,530	111,050	403,645	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.01	19301	BELOIT HEART STANDBY	2,002	0	0	0	0	193.01
194.00	07950	GUEST CENTER	18,011	0	0	0	0	194.00
194.01	07954	OTHER NONREIMBURSEABLE COST CENTER	6,693	0	2,428	0	613	194.01
194.02	07951	COMMUNITY SERVICES	51,308	0	13,936	0	3,518	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERSO	0	0	0	0	0	194.03
194.04	07952	AUXILIARY	12,835	0	33,898	0	8,558	194.04
194.05	07956	RETAIL PHARMACY	764,930	0	4,872	0	1,230	194.05
194.08	07955	DIALYSIS RENTED SPACE	0	0	0	0	0	194.08
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	16,761,836	0	2,078,664	111,050	417,564	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0239

Period:
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Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	269,084					10.00
11.00	01100	CAFETERIA	0	229,520				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	6,174	0	294,234		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	7,638	0	0	1,497,284	14.00
15.00	01500	PHARMACY	0	7,797	0	0	771	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	3,689	0	2,331	0	16.00
17.00	01700	SOCIAL SERVICE	0	341	0	16	1	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	9,834	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	1,783	0	0	0	22.00
23.00	02300	PARAMDICAL ED PROGRAM XRAY	0	620	0	0	0	23.00
23.01	02301	PASTORAL EDUCATION PROGRAM	0	0	0	0	0	23.01
23.02	02302	PARAMED EDUC EMT PROGRAM	0	1,532	0	10	35	23.02
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	229,364	51,969	0	92,889	77	30.00
31.00	03100	INTENSIVE CARE UNIT	38,783	11,474	0	27,166	0	31.00
34.01	03401	NEONATAL INTENSIVE CARE	0	15,098	0	38,941	183	34.01
34.02	03402	PEDIATRIC INTENSIVE CARE	0	0	0	0	0	34.02
40.00	04000	SUBPROVIDER - IPF	0	640	0	205	0	40.00
43.00	04300	NURSERY	0	5,374	0	14,110	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	261	0	287	108	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	17,984	0	34,315	219,841	50.00
51.00	05100	RECOVERY ROOM	0	2,201	0	5,975	57	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	6,647	0	16,834	0	52.00
53.00	05300	ANESTHESIOLOGY	0	1,568	0	3,378	50	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	12,274	0	7,258	442	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	2,382	0	3,143	275	55.00
56.00	05600	RADIOISOTOPE	0	524	0	18	15,215	56.00
57.00	05700	CT SCAN	0	3,426	0	188	0	57.00
58.00	05800	MRI	0	1,493	0	106	1,290	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	12,190	0	0	229,364	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	901	0	1,481	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	5,955	0	72	13	65.00
66.00	06600	PHYSICAL THERAPY	0	4,059	0	0	88	66.00
69.00	06900	ELECTROCARDIOLOGY	0	3,351	0	3,253	150	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,758	0	0	3,173	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	606,299	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	415,918	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	INJECTABLE DRUGS	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	37	0	39	447	74.00
76.00	03340	GI LAB	0	2,861	0	4,790	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPS	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09003	PAIN CENTER	0	1,719	0	3,599	0	90.01
90.02	09001	ANTENATAL TEST CENTER	0	1,481	0	1,332	547	90.02
90.03	09002	CHILD PSYCHIATRIC CLINIC	0	100	0	0	1	90.03
90.04	09004	SPECIAL SURGICAL SERVICES	0	777	0	2,175	0	90.04
90.05	09005	GENETIC SERVICES	0	718	0	15	5	90.05
90.06	09006	HBP	0	0	0	0	0	90.06
90.07	09007	MAIN	0	0	0	0	0	90.07
90.08	09008	RMB	0	0	0	0	0	90.08
90.09	09009	MULFORD	0	0	0	0	0	90.09
90.10	09010	ALPINE	0	0	0	0	0	90.10
90.11	09011	ROSCOE	0	0	0	0	0	90.11

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0239

Period:
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Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
90.12	09012	BYRON	0	0	0	0	0	90.12
90.13	09013	WINNEBAGO	0	0	0	0	0	90.13
90.14	09014	PERRYVILLE	0	0	0	0	0	90.14
90.15	09015	BELVIDERE	0	0	0	0	0	90.15
90.16	09016	SPRINGBROOK	0	0	0	0	0	90.16
90.17	09017	MCFARLAND	0	0	0	0	0	90.17
90.18	09018	CHERRYVALLEY	0	0	0	0	0	90.18
90.19	09019	KLECKNER	0	0	0	0	0	90.19
90.20	09020	GALLERIA	0	0	0	0	0	90.20
90.21	09021	RIVERSIDE MOB	0	0	0	0	0	90.21
90.22	09022	MULFORD-LENOX	0	0	0	0	0	90.22
91.00	09100	EMERGENCY	937	16,818	0	27,280	1	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	2,139	0	2,595	1,622	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	269,084	227,587	0	293,801	1,495,973	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.01	19301	BELOIT HEART STANDBY	0	16	0	0	0	193.01
194.00	07950	GUEST CENTER	0	0	0	0	0	194.00
194.01	07954	OTHER NONREIMBURSEABLE COST CENTER	0	163	0	0	0	194.01
194.02	07951	COMMUNITY SERVICES	0	145	0	433	31	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERSO	0	0	0	0	0	194.03
194.04	07952	AUXILIARY	0	247	0	0	1,265	194.04
194.05	07956	RETAIL PHARMACY	0	1,362	0	0	15	194.05
194.08	07955	DIALYSIS RENTED SPACE	0	0	0	0	0	194.08
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	269,084	229,520	0	294,234	1,497,284	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0239

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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING PROGRAM	
			15.00	16.00	17.00	19.00	20.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	2,116,252					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	292,772				16.00
17.00	01700	SOCIAL SERVICE	0	0	16,843			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
20.00	02000	NURSING PROGRAM	0	0	0		0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0			22.00
23.00	02300	PARAMDICAL ED PROGRAM XRAY	0	0	0			23.00
23.01	02301	PASTORAL EDUCATION PROGRAM	0	0	0			23.01
23.02	02302	PARAMED EDUC EMT PROGRAM	5,754	0	0			23.02
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	18,548	11,270	14,345			30.00
31.00	03100	INTENSIVE CARE UNIT	6,923	6,225	0			31.00
34.01	03401	NEONATAL INTENSIVE CARE	2,181	13,990	220			34.01
34.02	03402	PEDIATRIC INTENSIVE CARE	14	0	62			34.02
40.00	04000	SUBPROVIDER - IPF	0	29	2,093			40.00
43.00	04300	NURSERY	0	1,551	123			43.00
44.00	04400	SKILLED NURSING FACILITY	4	29	0			44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	13,346	18,747	0			50.00
51.00	05100	RECOVERY ROOM	1,117	1,746	0			51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,707	3,923	0			52.00
53.00	05300	ANESTHESIOLOGY	6,705	3,615	0			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,968	20,177	0			54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,194	4,034	0			55.00
56.00	05600	RADIOISOTOPE	526	3,614	0			56.00
57.00	05700	CT SCAN	4,878	21,228	0			57.00
58.00	05800	MRI	649	7,226	0			58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0			59.00
60.00	06000	LABORATORY	33	31,579	0			60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0			62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0			63.00
64.00	06400	INTRAVENOUS THERAPY	1,021	6,053	0			64.00
65.00	06500	RESPIRATORY THERAPY	83	6,614	0			65.00
66.00	06600	PHYSICAL THERAPY	0	2,817	0			66.00
69.00	06900	ELECTROCARDIOLOGY	5,703	8,216	0			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	37	1,966	0			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	30,297	0			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	18,804	0			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,323,837	44,869	0			73.00
73.01	07301	INJECTABLE DRUGS	0	0	0			73.01
74.00	07400	RENAL DIALYSIS	80	356	0			74.00
76.00	03340	GI LAB	1,685	2,938	0			76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0			76.98
76.99	07699	LITHOTRIPSY	0	0	0			76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0			90.00
90.01	09003	PAIN CENTER	683	2,319	0			90.01
90.02	09001	ANTENATAL TEST CENTER	315	2,407	0			90.02
90.03	09002	CHILD PSYCHIATRIC CLINIC	0	22	0			90.03
90.04	09004	SPECIAL SURGICAL SERVICES	3,841	571	0			90.04
90.05	09005	GENETIC SERVICES	0	51	0			90.05
90.06	09006	HBP	0	111	0			90.06
90.07	09007	MAIN	0	613	0			90.07
90.08	09008	RMB	0	74	0			90.08
90.09	09009	MULFORD	0	98	0			90.09
90.10	09010	ALPINE	0	107	0			90.10
90.11	09011	ROSCOE	0	106	0			90.11

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING PROGRAM	
			15.00	16.00	17.00	19.00	20.00	
90.12	09012	BYRON	0	19	0			90.12
90.13	09013	WINNEBAGO	0	64	0			90.13
90.14	09014	PERRYVILLE	0	547	0			90.14
90.15	09015	BELVIDERE	0	16	0			90.15
90.16	09016	SPRINGBROOK	0	217	0			90.16
90.17	09017	MCFARLAND	0	9	0			90.17
90.18	09018	CHERRYVALLEY	0	41	0			90.18
90.19	09019	KLECKNER	0	0	0			90.19
90.20	09020	GALLERIA	0	162	0			90.20
90.21	09021	RIVERSIDE MOB	0	140	0			90.21
90.22	09022	MULFORD-LENOX	0	6	0			90.22
91.00	09100	EMERGENCY	23,134	13,159	0			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92.00
95.00	09500	AMBULANCE SERVICES	311	0	0			95.00
99.10	09910	CORF	0	0	0			99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0			99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0			99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0			99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,431,277	292,772	16,843	0	0	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0			192.00
193.01	19301	BELOIT HEART STANDBY	0	0	0			193.01
194.00	07950	GUEST CENTER	0	0	0			194.00
194.01	07954	OTHER NONREIMBURSEABLE COST CENTER	0	0	0			194.01
194.02	07951	COMMUNITY SERVICES	49	0	0			194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERSO	0	0	0			194.03
194.04	07952	AUXILIARY	0	0	0			194.04
194.05	07956	RETAIL PHARMACY	684,926	0	0			194.05
194.08	07955	DIALYSIS RENTED SPACE	0	0	0			194.08
200.00		Cross Foot Adjustments				0		0 200.00
201.00		Negative Cost Centers	0	0	0	0		0 201.00
202.00		TOTAL (sum lines 118 through 201)	2,116,252	292,772	16,843	0		0 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0239

Period:
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Cost Center Description			INTERNS & RESIDENTS		PARAMDICAL ED PROGRAM XRAY	PASTORAL EDUCATION PROGRAM	PARAMED EDUC EMT PROGRAM	
			SERVICES-SALAR Y & FRINGES	SERVICES-OTHER PRGM COSTS				
			APPRV	APPRV				
			21.00	22.00	23.00	23.01	23.02	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
20.00	02000	NURSING PROGRAM						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	282,691					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		406,165				22.00
23.00	02300	PARAMDICAL ED PROGRAM XRAY			40,088			23.00
23.01	02301	PASTORAL EDUCATION PROGRAM				0		23.01
23.02	02302	PARAMED EDUC EMT PROGRAM					309,408	23.02
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS						30.00
31.00	03100	INTENSIVE CARE UNIT						31.00
34.01	03401	NEONATAL INTENSIVE CARE						34.01
34.02	03402	PEDIATRIC INTENSIVE CARE						34.02
40.00	04000	SUBPROVIDER - IPF						40.00
43.00	04300	NURSERY						43.00
44.00	04400	SKILLED NURSING FACILITY						44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM						50.00
51.00	05100	RECOVERY ROOM						51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM						52.00
53.00	05300	ANESTHESIOLOGY						53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC						54.00
55.00	05500	RADIOLOGY-THERAPEUTIC						55.00
56.00	05600	RADIOISOTOPE						56.00
57.00	05700	CT SCAN						57.00
58.00	05800	MRI						58.00
59.00	05900	CARDIAC CATHETERIZATION						59.00
60.00	06000	LABORATORY						60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.						63.00
64.00	06400	INTRAVENOUS THERAPY						64.00
65.00	06500	RESPIRATORY THERAPY						65.00
66.00	06600	PHYSICAL THERAPY						66.00
69.00	06900	ELECTROCARDIOLOGY						69.00
70.00	07000	ELECTROENCEPHALOGRAPHY						70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT						71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS						72.00
73.00	07300	DRUGS CHARGED TO PATIENTS						73.00
73.01	07301	INJECTABLE DRUGS						73.01
74.00	07400	RENAL DIALYSIS						74.00
76.00	03340	GI LAB						76.00
76.97	07697	CARDIAC REHABILITATION						76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY						76.98
76.99	07699	LITHOTRIPSY						76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC						90.00
90.01	09003	PAIN CENTER						90.01
90.02	09001	ANTENATAL TEST CENTER						90.02
90.03	09002	CHILD PSYCHIATRIC CLINIC						90.03
90.04	09004	SPECIAL SURGICAL SERVICES						90.04
90.05	09005	GENETIC SERVICES						90.05
90.06	09006	HBP						90.06
90.07	09007	MAIN						90.07
90.08	09008	RMB						90.08
90.09	09009	MULFORD						90.09

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			INTERNS & RESIDENTS		PARAMDICAL ED PROGRAM XRAY	PASTORAL EDUCATION PROGRAM	PARAMED EDUC EMT PROGRAM	
			SERVICES-SALAR Y & FRINGES	SERVICES-OTHER PRGM COSTS				
			APPRV	APPRV				
			21.00	22.00	23.00	23.01	23.02	
90.10	09010	ALPINE						90.10
90.11	09011	ROSCOE						90.11
90.12	09012	BYRON						90.12
90.13	09013	WINNEBAGO						90.13
90.14	09014	PERRYVILLE						90.14
90.15	09015	BELVIDERE						90.15
90.16	09016	SPRINGBROOK						90.16
90.17	09017	MCFARLAND						90.17
90.18	09018	CHERRYVALLEY						90.18
90.19	09019	KLECKNER						90.19
90.20	09020	GALLERIA						90.20
90.21	09021	RIVERSIDE MOB						90.21
90.22	09022	MULFORD-LENOX						90.22
91.00	09100	EMERGENCY						91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
99.10	09910	CORF						99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY						99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY						99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY						99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	0	0	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES						192.00
193.01	19301	BELOIT HEART STANDBY						193.01
194.00	07950	GUEST CENTER						194.00
194.01	07954	OTHER NONREIMBURSEABLE COST CENTER						194.01
194.02	07951	COMMUNITY SERVICES						194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERSO						194.03
194.04	07952	AUXILIARY						194.04
194.05	07956	RETAIL PHARMACY						194.05
194.08	07955	DIALYSIS RENTED SPACE						194.08
200.00		Cross Foot Adjustments	282,691	406,165	40,088	0	309,408	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	282,691	406,165	40,088	0	309,408	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0239

Period:
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To 06/30/2021Worksheet B
Part II
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Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
6.00	00600	MAINTENANCE & REPAIRS				6.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
12.00	01200	MAINTENANCE OF PERSONNEL				12.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS				19.00
20.00	02000	NURSING PROGRAM				20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV				22.00
23.00	02300	PARAMDICAL ED PROGRAM XRAY				23.00
23.01	02301	PASTORAL EDUCATION PROGRAM				23.01
23.02	02302	PARAMED EDUC EMT PROGRAM				23.02
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,421,990	0	3,421,990	30.00
31.00	03100	INTENSIVE CARE UNIT	1,053,999	0	1,053,999	31.00
34.01	03401	NEONATAL INTENSIVE CARE	1,275,405	0	1,275,405	34.01
34.02	03402	PEDIATRIC INTENSIVE CARE	3,326	0	3,326	34.02
40.00	04000	SUBPROVIDER - IPF	119,326	0	119,326	40.00
43.00	04300	NURSERY	479,180	0	479,180	43.00
44.00	04400	SKILLED NURSING FACILITY	22,484	0	22,484	44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,917,606	0	4,917,606	50.00
51.00	05100	RECOVERY ROOM	194,460	0	194,460	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	683,557	0	683,557	52.00
53.00	05300	ANESTHESIOLOGY	184,578	0	184,578	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,284,449	0	3,284,449	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	734,957	0	734,957	55.00
56.00	05600	RADIOISOTOPE	328,524	0	328,524	56.00
57.00	05700	CT SCAN	968,698	0	968,698	57.00
58.00	05800	MRI	973,810	0	973,810	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000	LABORATORY	1,941,388	0	1,941,388	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	44,574	0	44,574	64.00
65.00	06500	RESPIRATORY THERAPY	535,281	0	535,281	65.00
66.00	06600	PHYSICAL THERAPY	198,105	0	198,105	66.00
69.00	06900	ELECTROCARDIOLOGY	309,478	0	309,478	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	280,486	0	280,486	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,681,784	0	1,681,784	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,151,717	0	1,151,717	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,692,805	0	2,692,805	73.00
73.01	07301	INJECTABLE DRUGS	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	69,091	0	69,091	74.00
76.00	03340	GI LAB	1,331,781	0	1,331,781	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	76.98
76.99	07699	LITHOTRIPS	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	90.00
90.01	09003	PAIN CENTER	254,676	0	254,676	90.01
90.02	09001	ANTENATAL TEST CENTER	231,584	0	231,584	90.02
90.03	09002	CHILD PSYCHIATRIC CLINIC	6,923	0	6,923	90.03
90.04	09004	SPECIAL SURGICAL SERVICES	137,451	0	137,451	90.04
90.05	09005	GENETIC SERVICES	39,785	0	39,785	90.05
90.06	09006	HBP	20,911	0	20,911	90.06
90.07	09007	MAIN	91,859	0	91,859	90.07
90.08	09008	RMB	8,144	0	8,144	90.08
90.09	09009	MULFORD	150,441	0	150,441	90.09

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0239

Period:
From 07/01/2020
To 06/30/2021Worksheet B
Part II
Date/Time Prepared:
4/27/2022 12:54 pm

Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
90.10	09010	ALPINE	80,923	0	80,923	90.10
90.11	09011	ROSCOE	113,930	0	113,930	90.11
90.12	09012	BYRON	30,151	0	30,151	90.12
90.13	09013	WINNEBAGO	41,132	0	41,132	90.13
90.14	09014	PERRYVILLE	49,305	0	49,305	90.14
90.15	09015	BELVIDERE	2,634	0	2,634	90.15
90.16	09016	SPRINGBROOK	19,230	0	19,230	90.16
90.17	09017	MCFARLAND	1,216	0	1,216	90.17
90.18	09018	CHERRYVALLEY	30,996	0	30,996	90.18
90.19	09019	KLECKNER	0	0	0	90.19
90.20	09020	GALLERIA	43,850	0	43,850	90.20
90.21	09021	RIVERSIDE MOB	23,825	0	23,825	90.21
90.22	09022	MULFORD-LENOX	838	0	838	90.22
91.00	09100	EMERGENCY	1,570,534	0	1,570,534	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0		92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	127,735	0	127,735	95.00
99.10	09910	CORF	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	31,960,912	0	31,960,912	118.00
NONREIMBURSABLE COST CENTERS						
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	192.00
193.01	19301	BELOIT HEART STANDBY	2,023	0	2,023	193.01
194.00	07950	GUEST CENTER	38,807	0	38,807	194.00
194.01	07954	OTHER NONREIMBURSEABLE COST CENTER	23,856	0	23,856	194.01
194.02	07951	COMMUNITY SERVICES	77,251	0	77,251	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERSO	0	0	0	194.03
194.04	07952	AUXILIARY	69,430	0	69,430	194.04
194.05	07956	RETAIL PHARMACY	1,463,352	0	1,463,352	194.05
194.08	07955	DIALYSIS RENTED SPACE	0	0	0	194.08
200.00		Cross Foot Adjustments	1,038,352	0	1,038,352	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	34,673,983	0	34,673,983	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0239

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

Worksheet B-1

Date/Time Prepared:
4/27/2022 12:54 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	1,345,316					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		30,345,064				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4,963	20,408	96,314,272			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	448,388	15,333,822	2,843,807	-46,918,490	223,522,576	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	152,241	1,223,258	1,484,205	0	9,991,509	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	6,240	5,243	103,029	0	1,134,267	8.00
9.00	00900	HOUSEKEEPING	11,168	60,275	2,484,437	0	4,242,360	9.00
10.00	01000	DIETARY	23,676	50,689	863,758	0	1,620,973	10.00
11.00	01100	CAFETERIA	29,243	62,608	943,309	0	631,190	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	2,426	20,015	2,605,344	0	3,428,371	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	23,747	697,596	1,598,038	0	4,056,061	14.00
15.00	01500	PHARMACY	13,465	290,383	4,003,727	0	7,097,242	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,687	0	1,139,686	0	3,515,438	16.00
17.00	01700	SOCIAL SERVICE	2,172	0	79,120	0	103,155	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	3,036,483	0	3,628,901	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	3,592	8,903	3,043,989	0	5,068,098	22.00
23.00	02300	PARAMEDICAL ED PROGRAM XRAY	4,014	90	310,774	0	308,926	23.00
23.01	02301	PASTORAL EDUCATION PROGRAM	0	0	0	0	0	23.01
23.02	02302	PARAMED EDUC EMT PROGRAM	10,860	168,962	499,933	0	1,006,171	23.02
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	95,029	800,555	17,392,053	0	23,533,725	30.00
31.00	03100	INTENSIVE CARE UNIT	13,788	402,081	4,588,314	0	6,445,832	31.00
34.01	03401	NEONATAL INTENSIVE CARE	19,111	490,787	6,005,519	0	8,240,492	34.01
34.02	03402	PEDIATRIC INTENSIVE CARE	0	0	34,479	0	43,237	34.02
40.00	04000	SUBPROVIDER - IPF	1,821	79,272	222,123	0	365,358	40.00
43.00	04300	NURSERY	14,522	167,574	2,054,071	0	2,981,146	43.00
44.00	04400	SKILLED NURSING FACILITY	13,631	0	112,084	0	211,398	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	74,511	2,690,073	7,744,118	0	20,325,325	50.00
51.00	05100	RECOVERY ROOM	6,607	55,533	969,194	0	1,307,843	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	17,786	250,208	2,775,101	0	4,083,913	52.00
53.00	05300	ANESTHESIOLOGY	1,718	84,977	634,655	0	997,040	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	30,206	2,409,403	4,431,771	0	8,368,368	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	16,360	487,380	1,045,093	0	2,019,180	55.00
56.00	05600	RADIOISOTOPE	2,726	200,724	218,235	0	1,213,690	56.00
57.00	05700	CT SCAN	1,351	727,228	1,256,244	0	2,466,613	57.00
58.00	05800	MRI	7,273	778,614	713,598	0	1,759,557	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	28,163	563,517	4,049,182	0	12,175,235	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	1,667	329,782	0	444,380	64.00
65.00	06500	RESPIRATORY THERAPY	7,103	202,719	2,274,376	0	3,501,370	65.00
66.00	06600	PHYSICAL THERAPY	3,372	8,266	1,746,509	0	2,248,853	66.00
69.00	06900	ELECTROCARDIOLOGY	8,012	110,176	1,317,199	0	1,901,335	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	5,429	69,185	624,137	0	1,058,083	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	13,937,887	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	9,561,338	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	17,657,245	73.00
73.01	07301	INJECTABLE DRUGS	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	3,488	1,484	20,376	0	698,731	74.00
76.00	03340	GI LAB	15,067	822,082	1,043,102	0	2,445,200	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09003	PAIN CENTER	5,553	142,917	688,169	0	1,011,319	90.01
90.02	09001	ANTENATAL TEST CENTER	11,560	110,597	530,703	0	868,009	90.02
90.03	09002	CHILD PSYCHIATRIC CLINIC	109	2,040	107,636	0	56,504	90.03
90.04	09004	SPECIAL SURGICAL SERVICES	4,404	17,448	338,337	0	552,969	90.04
90.05	09005	GENETIC SERVICES	1,642	5,003	279,422	0	362,449	90.05
90.06	09006	HBP	0	0	0	0	277,376	90.06
90.07	09007	MAIN	0	0	0	0	1,216,789	90.07

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0239

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

Worksheet B-1

Date/Time Prepared:
4/27/2022 12:54 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	
90.08	09008	RMB	0	0	0	0	107,611	90.08
90.09	09009	MULFORD	41,833	0	0	0	165,757	90.09
90.10	09010	ALPINE	21,183	0	0	0	146,439	90.10
90.11	09011	ROSCOE	31,494	0	0	0	133,298	90.11
90.12	09012	BYRON	8,344	0	0	0	34,990	90.12
90.13	09013	WINNEBAGO	9,813	0	0	0	116,240	90.13
90.14	09014	PERRYVILLE	0	0	0	0	650,207	90.14
90.15	09015	BELVIDERE	0	0	0	0	34,917	90.15
90.16	09016	SPRINGBROOK	0	0	0	0	253,538	90.16
90.17	09017	MCFARLAND	0	0	0	0	16,092	90.17
90.18	09018	CHERRYVALLEY	7,977	0	0	0	62,087	90.18
90.19	09019	KLECKNER	0	0	0	0	0	90.19
90.20	09020	GALLERIA	10,287	0	0	0	130,343	90.20
90.21	09021	RIVERSIDE MOB	0	0	0	0	315,852	90.21
90.22	09022	MULFORD-LENOX	0	0	0	0	11,094	90.22
91.00	09100	EMERGENCY	37,292	641,384	5,828,792	0	8,845,835	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	5,610	28,723	1,061,136	0	915,765	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,326,057	30,293,869	95,475,149	-46,918,490	212,110,516	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.01	19301	BELOIT HEART STANDBY	0	0	21,303	0	26,693	193.01
194.00	07950	GUEST CENTER	0	20,211	0	0	240,188	194.00
194.01	07954	OTHER NONREIMBURSEABLE COST CENTER	848	13,195	57,528	0	89,247	194.01
194.02	07951	COMMUNITY SERVICES	4,868	5,520	163,315	0	684,208	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERSO	0	0	0	0	0	194.03
194.04	07952	AUXILIARY	11,841	7,263	67,365	0	171,162	194.04
194.05	07956	RETAIL PHARMACY	1,702	5,006	529,612	0	10,200,562	194.05
194.08	07955	DIALYSIS RENTED SPACE	0	0	0	0	0	194.08
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	583,799	31,223,410	18,790,944		46,918,490	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.433949	1.028945	0.195100		0.209905	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			23,153		16,761,836	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000240		0.074989	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0239

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

Worksheet B-1

Date/Time Prepared:
4/27/2022 12:54 pm

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS	0				6.00
7.00	00700	OPERATION OF PLANT	0	726,093			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	6,240	727,556		8.00
9.00	00900	HOUSEKEEPING	0	11,168	0	577,754	9.00
10.00	01000	DIETARY	0	23,676	0	23,676	192,221 10.00
11.00	01100	CAFETERIA	0	29,243	0	29,243	0 11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0 12.00
13.00	01300	NURSING ADMINISTRATION	0	2,426	0	2,426	0 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	23,747	65,105	23,747	0 14.00
15.00	01500	PHARMACY	0	13,465	0	13,465	0 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	5,687	0	5,687	0 16.00
17.00	01700	SOCIAL SERVICE	0	2,172	0	2,172	0 17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0 19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0 20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0 21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	3,592	0	3,592	0 22.00
23.00	02300	PARAMDICAL ED PROGRAM XRAY	0	4,014	0	4,014	0 23.00
23.01	02301	PASTORAL EDUCATION PROGRAM	0	0	0	0	0 23.01
23.02	02302	PARAMED EDUC EMT PROGRAM	0	10,860	0	10,860	0 23.02
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	95,029	188,360	95,029	163,847 30.00
31.00	03100	INTENSIVE CARE UNIT	0	13,788	64,351	13,788	27,705 31.00
34.01	03401	NEONATAL INTENSIVE CARE	0	19,111	23,557	19,111	0 34.01
34.02	03402	PEDIATRIC INTENSIVE CARE	0	0	0	0	0 34.02
40.00	04000	SUBPROVIDER - IPF	0	1,821	145	1,821	0 40.00
43.00	04300	NURSERY	0	14,522	20,832	14,522	0 43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0 44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	74,511	130,402	74,511	0 50.00
51.00	05100	RECOVERY ROOM	0	6,607	8,910	6,607	0 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	17,786	47,432	17,786	0 52.00
53.00	05300	ANESTHESIOLOGY	0	1,718	0	1,718	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	30,206	43,072	30,206	0 54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	16,360	6,819	16,360	0 55.00
56.00	05600	RADIOISOTOPE	0	2,726	463	2,726	0 56.00
57.00	05700	CT SCAN	0	1,351	0	1,351	0 57.00
58.00	05800	MRI	0	7,273	3,563	7,273	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0 59.00
60.00	06000	LABORATORY	0	28,163	6,515	28,163	0 60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0 62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0 63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0 64.00
65.00	06500	RESPIRATORY THERAPY	0	7,103	50	7,103	0 65.00
66.00	06600	PHYSICAL THERAPY	0	3,372	162	3,372	0 66.00
69.00	06900	ELECTROCARDIOLOGY	0	8,012	2,227	8,012	0 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	5,429	15	5,429	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
73.01	07301	INJECTABLE DRUGS	0	0	0	0	0 73.01
74.00	07400	RENAL DIALYSIS	0	3,488	1,202	3,488	0 74.00
76.00	03340	GI LAB	0	15,067	11,778	15,067	0 76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0 76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0 76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0 76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0 90.00
90.01	09003	PAIN CENTER	0	5,553	6,414	5,553	0 90.01
90.02	09001	ANTENATAL TEST CENTER	0	11,560	135	11,560	0 90.02
90.03	09002	CHILD PSYCHIATRIC CLINIC	0	109	0	109	0 90.03
90.04	09004	SPECIAL SURGICAL SERVICES	0	4,404	0	4,404	0 90.04
90.05	09005	GENETIC SERVICES	0	1,642	0	1,642	0 90.05
90.06	09006	HBP	0	0	0	0	0 90.06
90.07	09007	MAIN	0	0	0	0	0 90.07
90.08	09008	RMB	0	0	0	0	0 90.08
90.09	09009	MULFORD	0	41,833	0	0	0 90.09
90.10	09010	ALPINE	0	21,183	0	0	0 90.10

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0239

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

Worksheet B-1

Date/Time Prepared:
4/27/2022 12:54 pm

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	
90.11	09011 ROSCOE	0	31,494	0	0	0	90.11
90.12	09012 BYRON	0	8,344	0	0	0	90.12
90.13	09013 WINNEBAGO	0	9,813	0	0	0	90.13
90.14	09014 PERRYVILLE	0	0	0	0	0	90.14
90.15	09015 BELVIDERE	0	0	0	0	0	90.15
90.16	09016 SPRINGBROOK	0	0	0	0	0	90.16
90.17	09017 MCFARLAND	0	0	0	0	0	90.17
90.18	09018 CHERRYVALLEY	0	7,977	0	0	0	90.18
90.19	09019 KLECKNER	0	0	0	0	0	90.19
90.20	09020 GALLERIA	0	10,287	0	0	0	90.20
90.21	09021 RIVERSIDE MOB	0	0	0	0	0	90.21
90.22	09022 MULFORD-LENOX	0	0	0	0	0	90.22
91.00	09100 EMERGENCY	0	37,292	95,801	37,292	669	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92.00
95.00	09500 AMBULANCE SERVICES	0	5,610	246	5,610	0	95.00
99.10	09910 CORF	0	0	0	0	0	99.10
99.20	09920 OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930 OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940 OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	0	706,834	727,556	558,495	192,221	118.00
NONREIMBURSABLE COST CENTERS							
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.01	19301 BELOIT HEART STANDBY	0	0	0	0	0	193.01
194.00	07950 GUEST CENTER	0	0	0	0	0	194.00
194.01	07954 OTHER NONREIMBURSEABLE COST CENTER	0	848	0	848	0	194.01
194.02	07951 COMMUNITY SERVICES	0	4,868	0	4,868	0	194.02
194.03	07953 OTHER NONREIMBURSABLE COST CENTERSO	0	0	0	0	0	194.03
194.04	07952 AUXILIARY	0	11,841	0	11,841	0	194.04
194.05	07956 RETAIL PHARMACY	0	1,702	0	1,702	0	194.05
194.08	07955 DIALYSIS RENTED SPACE	0	0	0	0	0	194.08
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	0	12,088,777	1,476,245	5,318,790	2,573,367	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.000000	16.649075	2.029047	9.205977	13.387544	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	0	2,078,664	111,050	417,564	269,084	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000000	2.862807	0.152634	0.722737	1.399868	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0239

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

Worksheet B-1

Date/Time Prepared:
4/27/2022 12:54 pm

Cost Center Description			CAFETERIA (FTE'S)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRSNG HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			11.00	12.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	116,982					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	3,147	0	1,045,625			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,893	0	0	34,420,759		14.00
15.00	01500	PHARMACY	3,974	0	0	17,733	28,226,285	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,880	0	8,282	0	0	16.00
17.00	01700	SOCIAL SERVICE	174	0	56	27	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING PROGRAM	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	5,012	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	909	0	0	0	0	22.00
23.00	02300	PARAMDICAL ED PROGRAM XRAY	316	0	0	0	0	23.00
23.01	02301	PASTORAL EDUCATION PROGRAM	0	0	0	0	0	23.01
23.02	02302	PARAMED EDUC EMT PROGRAM	781	0	36	794	76,745	23.02
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	26,488	0	330,107	1,772	247,391	30.00
31.00	03100	INTENSIVE CARE UNIT	5,848	0	96,540	0	92,340	31.00
34.01	03401	NEONATAL INTENSIVE CARE	7,695	0	138,384	4,206	29,086	34.01
34.02	03402	PEDIATRIC INTENSIVE CARE	0	0	0	0	188	34.02
40.00	04000	SUBPROVIDER - IPF	326	0	730	0	0	40.00
43.00	04300	NURSERY	2,739	0	50,144	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	133	0	1,020	2,475	52	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	9,166	0	121,947	5,053,934	178,008	50.00
51.00	05100	RECOVERY ROOM	1,122	0	21,232	1,312	14,892	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,388	0	59,822	0	36,101	52.00
53.00	05300	ANESTHESIOLOGY	799	0	12,005	1,151	89,431	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,256	0	25,792	10,154	79,603	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	1,214	0	11,169	6,323	15,927	55.00
56.00	05600	RADIOISOTOPE	267	0	65	349,776	7,010	56.00
57.00	05700	CT SCAN	1,746	0	667	0	65,058	57.00
58.00	05800	MRI	761	0	376	29,662	8,650	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	6,213	0	0	5,272,859	441	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	459	0	5,264	0	13,613	64.00
65.00	06500	RESPIRATORY THERAPY	3,035	0	255	290	1,106	65.00
66.00	06600	PHYSICAL THERAPY	2,069	0	0	2,016	0	66.00
69.00	06900	ELECTROCARDIOLOGY	1,708	0	11,562	3,440	76,070	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	896	0	0	72,950	494	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	13,937,887	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	9,561,556	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	17,657,244	73.00
73.01	07301	INJECTABLE DRUGS	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	19	0	140	10,277	1,071	74.00
76.00	03340	GI LAB	1,458	0	17,021	0	22,468	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09003	PAIN CENTER	876	0	12,790	0	9,111	90.01
90.02	09001	ANTENATAL TEST CENTER	755	0	4,733	12,567	4,208	90.02
90.03	09002	CHILD PSYCHIATRIC CLINIC	51	0	0	33	0	90.03
90.04	09004	SPECIAL SURGICAL SERVICES	396	0	7,728	0	51,229	90.04
90.05	09005	GENETIC SERVICES	366	0	53	111	0	90.05
90.06	09006	HBP	0	0	0	0	0	90.06
90.07	09007	MAIN	0	0	0	0	0	90.07
90.08	09008	RMB	0	0	0	0	0	90.08
90.09	09009	MULFORD	0	0	0	0	0	90.09

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0239

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

Worksheet B-1

Date/Time Prepared:
4/27/2022 12:54 pm

Cost Center Description			CAFETERIA (FTE'S)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
			11.00	12.00	13.00	14.00	15.00	
90.10	09010	ALPINE	0	0	0	0	0	90.10
90.11	09011	ROSCOE	0	0	0	0	0	90.11
90.12	09012	BYRON	0	0	0	0	0	90.12
90.13	09013	WINNEBAGO	0	0	0	0	0	90.13
90.14	09014	PERRYVILLE	0	0	0	0	0	90.14
90.15	09015	BELVIDERE	0	0	0	0	0	90.15
90.16	09016	SPRINGBROOK	0	0	0	0	0	90.16
90.17	09017	MCFARLAND	0	0	0	0	0	90.17
90.18	09018	CHERRYVALLEY	0	0	0	0	0	90.18
90.19	09019	KLECKNER	0	0	0	0	0	90.19
90.20	09020	GALLERIA	0	0	0	0	0	90.20
90.21	09021	RIVERSIDE MOB	0	0	0	0	0	90.21
90.22	09022	MULFORD-LENOX	0	0	0	0	0	90.22
91.00	09100	EMERGENCY	8,572	0	96,945	22	308,557	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	1,090	0	9,221	37,289	4,145	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	115,997	0	1,044,086	34,390,616	19,090,239	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.01	19301	BELOIT HEART STANDBY	8	0	0	0	0	193.01
194.00	07950	GUEST CENTER	0	0	0	0	0	194.00
194.01	07954	OTHER NONREIMBURSEABLE COST CENTER	83	0	0	0	0	194.01
194.02	07951	COMMUNITY SERVICES	74	0	1,539	720	658	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERSO	0	0	0	0	0	194.03
194.04	07952	AUXILIARY	126	0	0	29,089	0	194.04
194.05	07956	RETAIL PHARMACY	694	0	0	334	9,135,388	194.05
194.08	07955	DIALYSIS RENTED SPACE	0	0	0	0	0	194.08
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,519,759	0	4,251,612	5,704,104	8,989,694	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	12.991392	0.000000	4.066096	0.165717	0.318487	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	229,520	0	294,234	1,497,284	2,116,252	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.962011	0.000000	0.281395	0.043499	0.074975	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0239

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

Worksheet B-1

Date/Time Prepared:
4/27/2022 12:54 pm

Cost Center Description			MEDICAL RECORDS & LIBRARY (GROSS REVE NUE)	SOCIAL SERVICE (VISITS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING PROGRAM (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALAR Y & FRINGES APPRV (ASSIGNED TIME)	
			16.00	17.00	19.00	20.00	21.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,225,621,095					16.00
17.00	01700	SOCIAL SERVICE	0	7,821				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
20.00	02000	NURSING PROGRAM	0	0		0		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0			100	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0				22.00
23.00	02300	PARAMDICAL ED PROGRAM XRAY	0	0				23.00
23.01	02301	PASTORAL EDUCATION PROGRAM	0	0				23.01
23.02	02302	PARAMED EDUC EMT PROGRAM	0	0				23.02
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	47,154,309	6,661	0	0	100	30.00
31.00	03100	INTENSIVE CARE UNIT	26,046,610	0	0	0	0	31.00
34.01	03401	NEONATAL INTENSIVE CARE	58,534,513	102	0	0	0	34.01
34.02	03402	PEDIATRIC INTENSIVE CARE	0	29	0	0	0	34.02
40.00	04000	SUBPROVIDER - IPF	122,290	972	0	0	0	40.00
43.00	04300	NURSERY	6,487,764	57	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	122,558	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	78,437,579	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	7,305,478	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	16,412,263	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	15,123,609	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	84,422,889	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	16,878,047	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	15,121,270	0	0	0	0	56.00
57.00	05700	CT SCAN	88,818,466	0	0	0	0	57.00
58.00	05800	MRI	30,234,872	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	132,130,846	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	25,324,618	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	27,673,735	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	11,785,945	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	34,376,245	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	8,225,239	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	126,764,990	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	78,678,650	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	188,386,230	0	0	0	0	73.00
73.01	07301	INJECTABLE DRUGS	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	1,491,286	0	0	0	0	74.00
76.00	03340	GI LAB	12,293,664	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPS	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09003	PAIN CENTER	9,701,021	0	0	0	0	90.01
90.02	09001	ANTENATAL TEST CENTER	10,070,362	0	0	0	0	90.02
90.03	09002	CHILD PSYCHIATRIC CLINIC	91,547	0	0	0	0	90.03
90.04	09004	SPECIAL SURGICAL SERVICES	2,389,849	0	0	0	0	90.04
90.05	09005	GENETIC SERVICES	214,185	0	0	0	0	90.05
90.06	09006	HBP	463,177	0	0	0	0	90.06
90.07	09007	MAIN	2,563,226	0	0	0	0	90.07

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0239

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

Worksheet B-1

Date/Time Prepared:
4/27/2022 12:54 pm

Cost Center Description			MEDICAL RECORDS & LIBRARY (GROSS REVE NUE)	SOCIAL SERVICE (VISITS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING PROGRAM (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALAR Y & FRINGES APPRV (ASSIGNED TIME)	
			16.00	17.00	19.00	20.00	21.00	
90.08	09008	RMB	308,454	0	0	0	0	90.08
90.09	09009	MULFORD	410,280	0	0	0	0	90.09
90.10	09010	ALPINE	448,212	0	0	0	0	90.10
90.11	09011	ROSCOE	443,393	0	0	0	0	90.11
90.12	09012	BYRON	79,019	0	0	0	0	90.12
90.13	09013	WINNEBAGO	266,540	0	0	0	0	90.13
90.14	09014	PERRYVILLE	2,288,363	0	0	0	0	90.14
90.15	09015	BELVIDERE	68,144	0	0	0	0	90.15
90.16	09016	SPRINGBROOK	909,830	0	0	0	0	90.16
90.17	09017	MCFARLAND	37,297	0	0	0	0	90.17
90.18	09018	CHERRYVALLEY	170,998	0	0	0	0	90.18
90.19	09019	KLECKNER	0	0	0	0	0	90.19
90.20	09020	GALLERIA	677,688	0	0	0	0	90.20
90.21	09021	RIVERSIDE MOB	584,963	0	0	0	0	90.21
90.22	09022	MULFORD-LENOX	23,088	0	0	0	0	90.22
91.00	09100	EMERGENCY	55,057,494	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	95.00
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,225,621,095	7,821	0	0	100	118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
193.01	19301	BELOIT HEART STANDBY	0	0	0	0	0	193.01
194.00	07950	GUEST CENTER	0	0	0	0	0	194.00
194.01	07954	OTHER NONREIMBURSEABLE COST CENTER	0	0	0	0	0	194.01
194.02	07951	COMMUNITY SERVICES	0	0	0	0	0	194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERSO	0	0	0	0	0	194.03
194.04	07952	AUXILIARY	0	0	0	0	0	194.04
194.05	07956	RETAIL PHARMACY	0	0	0	0	0	194.05
194.08	07955	DIALYSIS RENTED SPACE	0	0	0	0	0	194.08
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	4,458,482	183,458	0	0	4,455,738	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.003638	23.457103	0.000000	0.000000	44,557.380000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	292,772	16,843	0	0	282,691	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000239	2.153561	0.000000	0.000000	2,826.910000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)				0		206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)				0.000000		207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0239

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

Worksheet B-1

Date/Time Prepared:
4/27/2022 12:54 pm

Cost Center Description			INTERNS & RESIDENTS	PARAMEDICAL ED PROGRAM XRAY (ASSIGNED TIME)	PASTORAL EDUCATION PROGRAM (ASSIGNED TIME)	PARAMED EDUC EMT PROGRAM (TIME SPENT)				
			SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)							
			22.00					23.00	23.01	23.02
GENERAL SERVICE COST CENTERS										
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00			
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00			
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00			
5.00	00500	ADMINISTRATIVE & GENERAL					5.00			
6.00	00600	MAINTENANCE & REPAIRS					6.00			
7.00	00700	OPERATION OF PLANT					7.00			
8.00	00800	LAUNDRY & LINEN SERVICE					8.00			
9.00	00900	HOUSEKEEPING					9.00			
10.00	01000	DIETARY					10.00			
11.00	01100	CAFETERIA					11.00			
12.00	01200	MAINTENANCE OF PERSONNEL					12.00			
13.00	01300	NURSING ADMINISTRATION					13.00			
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00			
15.00	01500	PHARMACY					15.00			
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00			
17.00	01700	SOCIAL SERVICE					17.00			
19.00	01900	NONPHYSICIAN ANESTHETISTS					19.00			
20.00	02000	NURSING PROGRAM					20.00			
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	100				21.00			
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		100			22.00			
23.00	02300	PARAMEDICAL ED PROGRAM XRAY					23.00			
23.01	02301	PASTORAL EDUCATION PROGRAM			0		23.01			
23.02	02302	PARAMED EDUC EMT PROGRAM				640	23.02			
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	100	0	0	17	30.00			
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	31.00			
34.01	03401	NEONATAL INTENSIVE CARE	0	0	0	34	34.01			
34.02	03402	PEDIATRIC INTENSIVE CARE	0	0	0	0	34.02			
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	40.00			
43.00	04300	NURSERY	0	0	0	0	43.00			
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00			
ANCILLARY SERVICE COST CENTERS										
50.00	05000	OPERATING ROOM	0	0	0	89	50.00			
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00			
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	17	52.00			
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00			
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	100	0	0	54.00			
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00			
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00			
57.00	05700	CT SCAN	0	0	0	0	57.00			
58.00	05800	MRI	0	0	0	0	58.00			
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00			
60.00	06000	LABORATORY	0	0	0	0	60.00			
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30			
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00			
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00			
65.00	06500	RESPIRATORY THERAPY	0	0	0	13	65.00			
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00			
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00			
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00			
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00			
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00			
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00			
73.01	07301	INJECTABLE DRUGS	0	0	0	0	73.01			
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00			
76.00	03340	GI LAB	0	0	0	0	76.00			
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97			
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98			
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99			
OUTPATIENT SERVICE COST CENTERS										
90.00	09000	CLINIC	0	0	0	0	90.00			
90.01	09003	PAIN CENTER	0	0	0	0	90.01			
90.02	09001	ANTENATAL TEST CENTER	0	0	0	0	90.02			
90.03	09002	CHILD PSYCHIATRIC CLINIC	0	0	0	0	90.03			
90.04	09004	SPECIAL SURGICAL SERVICES	0	0	0	0	90.04			
90.05	09005	GENETIC SERVICES	0	0	0	0	90.05			
90.06	09006	HBP	0	0	0	0	90.06			
90.07	09007	MAIN	0	0	0	0	90.07			

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0239

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

Worksheet B-1

Date/Time Prepared:
4/27/2022 12:54 pm

Cost Center Description			INTERNS & RESIDENTS	PARAMDICAL ED PROGRAM XRAY (ASSIGNED TIME)	PASTORAL EDUCATION PROGRAM (ASSIGNED TIME)	PARAMED EDUC EMT PROGRAM (TIME SPENT)		
			SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)					
			22.00	23.00	23.01	23.02		
90.08	09008	RMB	0	0	0	0		90.08
90.09	09009	MULFORD	0	0	0	0		90.09
90.10	09010	ALPINE	0	0	0	0		90.10
90.11	09011	ROSCOE	0	0	0	0		90.11
90.12	09012	BYRON	0	0	0	0		90.12
90.13	09013	WINNEBAGO	0	0	0	0		90.13
90.14	09014	PERRYVILLE	0	0	0	0		90.14
90.15	09015	BELVIDERE	0	0	0	0		90.15
90.16	09016	SPRINGBROOK	0	0	0	0		90.16
90.17	09017	MCFARLAND	0	0	0	0		90.17
90.18	09018	CHERRYVALLEY	0	0	0	0		90.18
90.19	09019	KLECKNER	0	0	0	0		90.19
90.20	09020	GALLERIA	0	0	0	0		90.20
90.21	09021	RIVERSIDE MOB	0	0	0	0		90.21
90.22	09022	MULFORD-LENOX	0	0	0	0		90.22
91.00	09100	EMERGENCY	0	0	0	470		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0		95.00
99.10	09910	CORF	0	0	0	0		99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0		99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0		99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0		99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	100	100	0	640		118.00
NONREIMBURSABLE COST CENTERS								
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192.00
193.01	19301	BELOIT HEART STANDBY	0	0	0	0		193.01
194.00	07950	GUEST CENTER	0	0	0	0		194.00
194.01	07954	OTHER NONREIMBURSEABLE COST CENTER	0	0	0	0		194.01
194.02	07951	COMMUNITY SERVICES	0	0	0	0		194.02
194.03	07953	OTHER NONREIMBURSABLE COST CENTERSO	0	0	0	0		194.03
194.04	07952	AUXILIARY	0	0	0	0		194.04
194.05	07956	RETAIL PHARMACY	0	0	0	0		194.05
194.08	07955	DIALYSIS RENTED SPACE	0	0	0	0		194.08
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	6,236,597	481,658	0	1,533,023		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	62,365.970000	4,816.580000	0.000000	2,395.348437		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	406,165	40,088	0	309,408		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	4,061.650000	400.880000	0.000000	483.450000		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)		0	0	0		206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)		0.000000	0.000000	0.000000		207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0239

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
4/27/2022 12:54 pm

		Title XVIII		Hospital		PPS
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		
				Total Costs	RCE Disallowance	
		1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	35,640,207	35,640,207	0	35,640,207 30.00
31.00	03100	INTENSIVE CARE UNIT	9,249,488	9,249,488	0	9,249,488 31.00
34.01	03401	NEONATAL INTENSIVE CARE	11,481,522	11,481,522	0	11,481,522 34.01
34.02	03402	PEDIATRIC INTENSIVE CARE	53,053	53,053	0	53,053 34.02
40.00	04000	SUBPROVIDER - IPF	519,872	519,872	0	519,872 40.00
43.00	04300	NURSERY	4,289,051	4,289,051	0	4,289,051 43.00
44.00	04400	SKILLED NURSING FACILITY	262,519	262,519	0	262,519 44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	28,790,475	28,790,475	0	28,790,475 50.00
51.00	05100	RECOVERY ROOM	1,903,713	1,903,713	0	1,903,713 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,896,431	5,896,431	0	5,896,431 52.00
53.00	05300	ANESTHESIOLOGY	1,393,630	1,393,630	0	1,393,630 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,995,274	11,995,274	0	11,995,274 54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	3,008,550	3,008,550	0	3,008,550 55.00
56.00	05600	RADIOISOTOPE	1,658,810	1,658,810	0	1,658,810 56.00
57.00	05700	CT SCAN	3,388,534	3,388,534	0	3,388,534 57.00
58.00	05800	MRI	2,453,249	2,453,249	0	2,453,249 58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0 59.00
60.00	06000	LABORATORY	16,907,603	16,907,603	0	16,907,603 60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0 62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0 63.00
64.00	06400	INTRAVENOUS THERAPY	661,492	661,492	0	661,492 64.00
65.00	06500	RESPIRATORY THERAPY	4,592,757	4,592,757	0	4,592,757 65.00
66.00	06600	PHYSICAL THERAPY	2,878,501	2,878,501	0	2,878,501 66.00
69.00	06900	ELECTROCARDIOLOGY	2,731,163	2,731,163	0	2,731,163 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,474,386	1,474,386	0	1,474,386 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	19,634,435	19,634,435	0	19,634,435 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,439,056	13,439,056	0	13,439,056 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	27,672,203	27,672,203	0	27,672,203 73.00
73.01	07301	INJECTABLE DRUGS	0	0	0	0 73.01
74.00	07400	RENAL DIALYSIS	946,304	946,304	0	946,304 74.00
76.00	03340	GI LAB	3,511,946	3,511,946	0	3,511,946 76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0 76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0 76.98
76.99	07699	LITHOTRIPSY	0	0	0	0 76.99
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0 90.00
90.01	09003	PAIN CENTER	1,481,766	1,481,766	0	1,481,766 90.01
90.02	09001	ANTENATAL TEST CENTER	1,418,479	1,418,479	0	1,418,479 90.02
90.03	09002	CHILD PSYCHIATRIC CLINIC	72,183	72,183	0	72,183 90.03
90.04	09004	SPECIAL SURGICAL SERVICES	844,484	844,484	0	844,484 90.04
90.05	09005	GENETIC SERVICES	486,751	486,751	0	486,751 90.05
90.06	09006	HBP	337,284	337,284	0	337,284 90.06
90.07	09007	MAIN	1,481,524	1,481,524	0	1,481,524 90.07
90.08	09008	RMB	131,321	131,321	0	131,321 90.08
90.09	09009	MULFORD	898,524	898,524	0	898,524 90.09
90.10	09010	ALPINE	531,485	531,485	0	531,485 90.10
90.11	09011	ROSCOE	687,237	687,237	0	687,237 90.11
90.12	09012	BYRON	181,542	181,542	0	181,542 90.12
90.13	09013	WINNEBAGO	304,986	304,986	0	304,986 90.13
90.14	09014	PERRYVILLE	795,014	795,014	0	795,014 90.14
90.15	09015	BELVIDERE	42,494	42,494	0	42,494 90.15
90.16	09016	SPRINGBROOK	310,067	310,067	0	310,067 90.16
90.17	09017	MCFARLAND	19,606	19,606	0	19,606 90.17
90.18	09018	CHERRYVALLEY	208,551	208,551	0	208,551 90.18
90.19	09019	KLECKNER	0	0	0	0 90.19
90.20	09020	GALLERIA	331,437	331,437	0	331,437 90.20
90.21	09021	RIVERSIDE MOB	384,279	384,279	0	384,279 90.21
90.22	09022	MULFORD-LENOX	13,507	13,507	0	13,507 90.22
91.00	09100	EMERGENCY	13,800,084	13,800,084	0	13,800,084 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	5,532,081	5,532,081	0	5,532,081 92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,312,688	1,312,688	0	1,312,688 95.00
99.10	09910	CORF	0	0	0	0 99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0 99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0 99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0 99.40
200.00		Subtotal (see instructions)	248,041,598	248,041,598	0	248,041,598 200.00
201.00		Less Observation Beds	5,532,081	5,532,081	0	5,532,081 201.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0239

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
4/27/2022 12:54 pm

		Title XVIII		Hospital		PPS	
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	RCE Disallowance	Total Costs	
				1.00	2.00	3.00	
202.00	Total (see instructions)	242,509,517	0	242,509,517	0	242,509,517	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0239

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
4/27/2022 12:54 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	58,243,041		58,243,041		30.00
31.00	03100	INTENSIVE CARE UNIT	26,154,207		26,154,207		31.00
34.01	03401	NEONATAL INTENSIVE CARE	58,534,513		58,534,513		34.01
34.02	03402	PEDIATRIC INTENSIVE CARE	0		0		34.02
40.00	04000	SUBPROVIDER - IPF	122,290		122,290		40.00
43.00	04300	NURSERY	6,487,764		6,487,764		43.00
44.00	04400	SKILLED NURSING FACILITY	122,558		122,558		44.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	31,173,635	47,266,408	78,440,043	0.367038	50.00
51.00	05100	RECOVERY ROOM	2,872,985	4,433,877	7,306,862	0.260538	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	14,628,214	2,153,702	16,781,916	0.351356	52.00
53.00	05300	ANESTHESIOLOGY	5,864,030	9,259,580	15,123,610	0.092149	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	41,754,090	42,668,800	84,422,890	0.142086	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	130,731	16,747,316	16,878,047	0.178252	55.00
56.00	05600	RADIOISOTOPE	2,166,462	12,954,808	15,121,270	0.109700	56.00
57.00	05700	CT SCAN	30,177,186	58,641,279	88,818,465	0.038151	57.00
58.00	05800	MRI	7,368,903	22,865,969	30,234,872	0.081140	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	58,734,154	73,396,692	132,130,846	0.127961	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	502,608	24,822,010	25,324,618	0.026121	64.00
65.00	06500	RESPIRATORY THERAPY	25,958,517	1,715,217	27,673,734	0.165961	65.00
66.00	06600	PHYSICAL THERAPY	8,352,519	3,433,425	11,785,944	0.244232	66.00
69.00	06900	ELECTROCARDIOLOGY	13,367,887	21,008,358	34,376,245	0.079449	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,703,164	6,522,075	8,225,239	0.179251	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	73,629,951	53,135,039	126,764,990	0.154888	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	37,490,953	41,187,697	78,678,650	0.170809	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	75,904,217	112,482,013	188,386,230	0.146891	73.00
73.01	07301	INJECTABLE DRUGS	0	0	0	0.000000	73.01
74.00	07400	RENAL DIALYSIS	1,422,713	68,573	1,491,286	0.634556	74.00
76.00	03340	GI LAB	1,652,419	10,641,246	12,293,665	0.285671	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	76.99
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0.000000	90.00
90.01	09003	PAIN CENTER	15,126	9,685,895	9,701,021	0.152743	90.01
90.02	09001	ANTENATAL TEST CENTER	295,017	9,775,345	10,070,362	0.140857	90.02
90.03	09002	CHILD PSYCHIATRIC CLINIC	0	91,547	91,547	0.788480	90.03
90.04	09004	SPECIAL SURGICAL SERVICES	15,793	2,374,057	2,389,850	0.353363	90.04
90.05	09005	GENETIC SERVICES	247	213,938	214,185	2.272573	90.05
90.06	09006	HBP	2,808	460,369	463,177	0.728197	90.06
90.07	09007	MAIN	12,577	2,550,649	2,563,226	0.577992	90.07
90.08	09008	RMB	879	307,575	308,454	0.425739	90.08
90.09	09009	MULFORD	1,970	408,310	410,280	2.190026	90.09
90.10	09010	ALPINE	1,832	446,380	448,212	1.185789	90.10
90.11	09011	ROSCOE	2,630	440,763	443,393	1.549950	90.11
90.12	09012	BYRON	721	78,297	79,018	2.297477	90.12
90.13	09013	WINNEBAGO	1,753	264,787	266,540	1.144241	90.13
90.14	09014	PERRYVILLE	12,816	2,275,547	2,288,363	0.347416	90.14
90.15	09015	BELVIDERE	358	67,786	68,144	0.623591	90.15
90.16	09016	SPRINGBROOK	227	909,603	909,830	0.340797	90.16
90.17	09017	MCFARLAND	0	37,297	37,297	0.525672	90.17
90.18	09018	CHERRYVALLEY	1,038	169,960	170,998	1.219611	90.18
90.19	09019	KLECKNER	0	0	0	0.000000	90.19
90.20	09020	GALLERIA	0	677,688	677,688	0.489070	90.20
90.21	09021	RIVERSIDE MOB	3,285	581,678	584,963	0.656929	90.21
90.22	09022	MULFORD-LENOX	0	23,088	23,088	0.585023	90.22
91.00	09100	EMERGENCY	19,036,154	37,138,175	56,174,329	0.245665	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,403,953	11,282,713	12,686,666	0.436055	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	95.00
99.10	09910	CORF	0	0	0		99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0		99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0		99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0		99.40
200.00		Subtotal (see instructions)	605,328,895	645,665,531	1,250,994,426		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	605,328,895	645,665,531	1,250,994,426		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0239

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
4/27/2022 12:54 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
34.01	03401	NEONATAL INTENSIVE CARE			34.01
34.02	03402	PEDIATRIC INTENSIVE CARE			34.02
40.00	04000	SUBPROVIDER - IPF			40.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.367038		50.00
51.00	05100	RECOVERY ROOM	0.260538		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.351356		52.00
53.00	05300	ANESTHESIOLOGY	0.092149		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.142086		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.178252		55.00
56.00	05600	RADIOISOTOPE	0.109700		56.00
57.00	05700	CT SCAN	0.038151		57.00
58.00	05800	MRI	0.081140		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.127961		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000		62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
64.00	06400	INTRAVENOUS THERAPY	0.026121		64.00
65.00	06500	RESPIRATORY THERAPY	0.165961		65.00
66.00	06600	PHYSICAL THERAPY	0.244232		66.00
69.00	06900	ELECTROCARDIOLOGY	0.079449		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.179251		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.154888		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.170809		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.146891		73.00
73.01	07301	INJECTABLE DRUGS	0.000000		73.01
74.00	07400	RENAL DIALYSIS	0.634556		74.00
76.00	03340	GI LAB	0.285671		76.00
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000		76.98
76.99	07699	LITHOTRIPSY	0.000000		76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.000000		90.00
90.01	09003	PAIN CENTER	0.152743		90.01
90.02	09001	ANTENATAL TEST CENTER	0.140857		90.02
90.03	09002	CHILD PSYCHIATRIC CLINIC	0.788480		90.03
90.04	09004	SPECIAL SURGICAL SERVICES	0.353363		90.04
90.05	09005	GENETIC SERVICES	2.272573		90.05
90.06	09006	HBP	0.728197		90.06
90.07	09007	MAIN	0.577992		90.07
90.08	09008	RMB	0.425739		90.08
90.09	09009	MULFORD	2.190026		90.09
90.10	09010	ALPINE	1.185789		90.10
90.11	09011	ROSCOE	1.549950		90.11
90.12	09012	BYRON	2.297477		90.12
90.13	09013	WINNEBAGO	1.144241		90.13
90.14	09014	PERRYVILLE	0.347416		90.14
90.15	09015	BELVIDERE	0.623591		90.15
90.16	09016	SPRINGBROOK	0.340797		90.16
90.17	09017	MCFARLAND	0.525672		90.17
90.18	09018	CHERRYVALLEY	1.219611		90.18
90.19	09019	KLECKNER	0.000000		90.19
90.20	09020	GALLERIA	0.489070		90.20
90.21	09021	RIVERSIDE MOB	0.656929		90.21
90.22	09022	MULFORD-LENOX	0.585023		90.22
91.00	09100	EMERGENCY	0.245665		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.436055		92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES	0.000000		95.00
99.10	09910	CORF			99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY			99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY			99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY			99.40
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0239

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
4/27/2022 12:54 pm

			Title XIX	Hospital	Cost	
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	46,332,542		46,332,542	0
31.00	03100	INTENSIVE CARE UNIT	9,249,488		9,249,488	0
34.01	03401	NEONATAL INTENSIVE CARE	11,481,522		11,481,522	0
34.02	03402	PEDIATRIC INTENSIVE CARE	53,053		53,053	0
40.00	04000	SUBPROVIDER - IPF	519,872		519,872	0
43.00	04300	NURSERY	4,289,051		4,289,051	0
44.00	04400	SKILLED NURSING FACILITY	262,519		262,519	0
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	28,790,475		28,790,475	0
51.00	05100	RECOVERY ROOM	1,903,713		1,903,713	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,896,431		5,896,431	0
53.00	05300	ANESTHESIOLOGY	1,393,630		1,393,630	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,995,274		11,995,274	0
55.00	05500	RADIOLOGY-THERAPEUTIC	3,008,550		3,008,550	0
56.00	05600	RADIOISOTOPE	1,658,810		1,658,810	0
57.00	05700	CT SCAN	3,388,534		3,388,534	0
58.00	05800	MRI	2,453,249		2,453,249	0
59.00	05900	CARDIAC CATHETERIZATION	0		0	0
60.00	06000	LABORATORY	16,907,603		16,907,603	0
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0		0	0
64.00	06400	INTRAVENOUS THERAPY	661,492		661,492	0
65.00	06500	RESPIRATORY THERAPY	4,592,757	0	4,592,757	0
66.00	06600	PHYSICAL THERAPY	2,878,501	0	2,878,501	0
69.00	06900	ELECTROCARDIOLOGY	2,731,163		2,731,163	0
70.00	07000	ELECTROENCEPHALOGRAPHY	1,474,386		1,474,386	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	19,634,435		19,634,435	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	13,439,056		13,439,056	0
73.00	07300	DRUGS CHARGED TO PATIENTS	27,672,203		27,672,203	0
73.01	07301	INJECTABLE DRUGS	0		0	0
74.00	07400	RENAL DIALYSIS	946,304		946,304	0
76.00	03340	GI LAB	3,511,946		3,511,946	0
76.97	07697	CARDIAC REHABILITATION	0		0	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0
76.99	07699	LITHOTRIPSY	0		0	0
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0		0	0
90.01	09003	PAIN CENTER	1,481,766		1,481,766	0
90.02	09001	ANTENATAL TEST CENTER	1,418,479		1,418,479	0
90.03	09002	CHILD PSYCHIATRIC CLINIC	72,183		72,183	0
90.04	09004	SPECIAL SURGICAL SERVICES	844,484		844,484	0
90.05	09005	GENETIC SERVICES	486,751		486,751	0
90.06	09006	HBP	337,284		337,284	0
90.07	09007	MAIN	1,481,524		1,481,524	0
90.08	09008	RMB	131,321		131,321	0
90.09	09009	MULFORD	898,524		898,524	0
90.10	09010	ALPINE	531,485		531,485	0
90.11	09011	ROSCOE	687,237		687,237	0
90.12	09012	BYRON	181,542		181,542	0
90.13	09013	WINNEBAGO	304,986		304,986	0
90.14	09014	PERRYVILLE	795,014		795,014	0
90.15	09015	BELVIDERE	42,494		42,494	0
90.16	09016	SPRINGBROOK	310,067		310,067	0
90.17	09017	MCFARLAND	19,606		19,606	0
90.18	09018	CHERRYVALLEY	208,551		208,551	0
90.19	09019	KLECKNER	0		0	0
90.20	09020	GALLERIA	331,437		331,437	0
90.21	09021	RIVERSIDE MOB	384,279		384,279	0
90.22	09022	MULFORD-LENOX	13,507		13,507	0
91.00	09100	EMERGENCY	13,800,084		13,800,084	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	7,191,769		7,191,769	0
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	1,312,688		1,312,688	0
99.10	09910	CORF	0		0	0
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0		0	0
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0		0	0
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0		0	0
200.00		Subtotal (see instructions)	260,393,621	0	260,393,621	0
201.00		Less Observation Beds	7,191,769		7,191,769	0

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0239

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
4/27/2022 12:54 pm

		Title XIX		Hospital		Cost	
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
				Total Costs	RCE Disallowance	Total Costs	
				1.00	2.00	3.00	
202.00	Total (see instructions)	253,201,852	0	253,201,852	0	0	202.00

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			Title XIX			Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0		0			30.00
31.00	03100	INTENSIVE CARE UNIT	0		0			31.00
34.01	03401	NEONATAL INTENSIVE CARE	0		0			34.01
34.02	03402	PEDIATRIC INTENSIVE CARE	0		0			34.02
40.00	04000	SUBPROVIDER - IPF	0		0			40.00
43.00	04300	NURSERY	0		0			43.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0.000000	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0.000000	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0.000000	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000	57.00
58.00	05800	MRI	0	0	0	0.000000	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	0.000000	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0.000000	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0.000000	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0.000000	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0.000000	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0.000000	0.000000	73.00
73.01	07301	INJECTABLE DRUGS	0	0	0	0.000000	0.000000	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
76.00	03340	GI LAB	0	0	0	0.000000	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0.000000	0.000000	90.00
90.01	09003	PAIN CENTER	0	0	0	0.000000	0.000000	90.01
90.02	09001	ANTENATAL TEST CENTER	0	0	0	0.000000	0.000000	90.02
90.03	09002	CHILD PSYCHIATRIC CLINIC	0	0	0	0.000000	0.000000	90.03
90.04	09004	SPECIAL SURGICAL SERVICES	0	0	0	0.000000	0.000000	90.04
90.05	09005	GENETIC SERVICES	0	0	0	0.000000	0.000000	90.05
90.06	09006	HBP	0	0	0	0.000000	0.000000	90.06
90.07	09007	MAIN	0	0	0	0.000000	0.000000	90.07
90.08	09008	RMB	0	0	0	0.000000	0.000000	90.08
90.09	09009	MULFORD	0	0	0	0.000000	0.000000	90.09
90.10	09010	ALPINE	0	0	0	0.000000	0.000000	90.10
90.11	09011	ROSCOE	0	0	0	0.000000	0.000000	90.11
90.12	09012	BYRON	0	0	0	0.000000	0.000000	90.12
90.13	09013	WINNEBAGO	0	0	0	0.000000	0.000000	90.13
90.14	09014	PERRYVILLE	0	0	0	0.000000	0.000000	90.14
90.15	09015	BELVIDERE	0	0	0	0.000000	0.000000	90.15
90.16	09016	SPRINGBROOK	0	0	0	0.000000	0.000000	90.16
90.17	09017	MCFARLAND	0	0	0	0.000000	0.000000	90.17
90.18	09018	CHERRYVALLEY	0	0	0	0.000000	0.000000	90.18
90.19	09019	KLECKNER	0	0	0	0.000000	0.000000	90.19
90.20	09020	GALLERIA	0	0	0	0.000000	0.000000	90.20
90.21	09021	RIVERSIDE MOB	0	0	0	0.000000	0.000000	90.21
90.22	09022	MULFORD-LENOX	0	0	0	0.000000	0.000000	90.22
91.00	09100	EMERGENCY	0	0	0	0.000000	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0.000000	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0.000000	0.000000	95.00
99.10	09910	CORF	0	0	0			99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0			99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0			99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0			99.40
200.00		Subtotal (see instructions)	0	0	0			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	0	0	0			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0239

Period:
From 07/01/2020
To 06/30/2021Worksheet C
Part I
Date/Time Prepared:
4/27/2022 12:54 pm

Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
34.01	03401	NEONATAL INTENSIVE CARE				34.01
34.02	03402	PEDIATRIC INTENSIVE CARE				34.02
40.00	04000	SUBPROVIDER - IPF				40.00
43.00	04300	NURSERY				43.00
44.00	04400	SKILLED NURSING FACILITY				44.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000			50.00
51.00	05100	RECOVERY ROOM	0.000000			51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000			52.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000			54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000			55.00
56.00	05600	RADIOISOTOPE	0.000000			56.00
57.00	05700	CT SCAN	0.000000			57.00
58.00	05800	MRI	0.000000			58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000			59.00
60.00	06000	LABORATORY	0.000000			60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000			62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000			63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000			64.00
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000			73.00
73.01	07301	INJECTABLE DRUGS	0.000000			73.01
74.00	07400	RENAL DIALYSIS	0.000000			74.00
76.00	03340	GI LAB	0.000000			76.00
76.97	07697	CARDIAC REHABILITATION	0.000000			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000			76.98
76.99	07699	LITHOTRIPSY	0.000000			76.99
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000			90.00
90.01	09003	PAIN CENTER	0.000000			90.01
90.02	09001	ANTENATAL TEST CENTER	0.000000			90.02
90.03	09002	CHILD PSYCHIATRIC CLINIC	0.000000			90.03
90.04	09004	SPECIAL SURGICAL SERVICES	0.000000			90.04
90.05	09005	GENETIC SERVICES	0.000000			90.05
90.06	09006	HBP	0.000000			90.06
90.07	09007	MAIN	0.000000			90.07
90.08	09008	RMB	0.000000			90.08
90.09	09009	MULFORD	0.000000			90.09
90.10	09010	ALPINE	0.000000			90.10
90.11	09011	ROSCOE	0.000000			90.11
90.12	09012	BYRON	0.000000			90.12
90.13	09013	WINNEBAGO	0.000000			90.13
90.14	09014	PERRYVILLE	0.000000			90.14
90.15	09015	BELVIDERE	0.000000			90.15
90.16	09016	SPRINGBROOK	0.000000			90.16
90.17	09017	MCFARLAND	0.000000			90.17
90.18	09018	CHERRYVALLEY	0.000000			90.18
90.19	09019	KLECKNER	0.000000			90.19
90.20	09020	GALLERIA	0.000000			90.20
90.21	09021	RIVERSIDE MOB	0.000000			90.21
90.22	09022	MULFORD-LENOX	0.000000			90.22
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000			95.00
99.10	09910	CORF				99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY				99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY				99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY				99.40
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0239

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part I
Date/Time Prepared:
4/27/2022 12:54 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	3,421,990	0	3,421,990	37,334	91.66	30.00	
31.00	INTENSIVE CARE UNIT	1,053,999		1,053,999	5,333	197.64	31.00	
34.01	NEONATAL INTENSIVE CARE	1,275,405		1,275,405	9,653	132.13	34.01	
34.02	PEDIATRIC INTENSIVE CARE	3,326		3,326	0	0.00	34.02	
40.00	SUBPROVIDER - IPF	119,326	0	119,326	74	1,612.51	40.00	
43.00	NURSERY	479,180		479,180	1,530	313.19	43.00	
44.00	SKILLED NURSING FACILITY	22,484		22,484	0	0.00	44.00	
200.00	Total (lines 30 through 199)	6,375,710		6,375,710	53,924		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	10,372	950,698					30.00
31.00	INTENSIVE CARE UNIT	1,663	328,675					
34.01	NEONATAL INTENSIVE CARE	0	0					
34.02	PEDIATRIC INTENSIVE CARE	0	0					
40.00	SUBPROVIDER - IPF	13	20,963					
43.00	NURSERY	0	0					
44.00	SKILLED NURSING FACILITY	0	0					
200.00	Total (lines 30 through 199)	12,048	1,300,336					

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0239

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part II
Date/Time Prepared:
4/27/2022 12:54 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	4,917,606	78,440,043	0.062693	8,636,913	541,474	50.00
51.00	05100	RECOVERY ROOM	194,460	7,306,862	0.026613	833,644	22,186	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	683,557	16,781,916	0.040732	44,921	1,830	52.00
53.00	05300	ANESTHESIOLOGY	184,578	15,123,610	0.012205	1,486,876	18,147	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,284,449	84,422,890	0.038905	13,483,476	524,575	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	734,957	16,878,047	0.043545	39,738	1,730	55.00
56.00	05600	RADIOISOTOPE	328,524	15,121,270	0.021726	809,371	17,584	56.00
57.00	05700	CT SCAN	968,698	88,818,465	0.010906	10,217,156	111,428	57.00
58.00	05800	MRI	973,810	30,234,872	0.032208	2,285,874	73,623	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	1,941,388	132,130,846	0.014693	18,481,263	271,545	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	44,574	25,324,618	0.001760	159,395	281	64.00
65.00	06500	RESPIRATORY THERAPY	535,281	27,673,734	0.019343	6,663,155	128,885	65.00
66.00	06600	PHYSICAL THERAPY	198,105	11,785,944	0.016809	3,062,293	51,474	66.00
69.00	06900	ELECTROCARDIOLOGY	309,478	34,376,245	0.009003	4,825,936	43,448	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	280,486	8,225,239	0.034101	397,350	13,550	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,681,784	126,764,990	0.013267	22,138,645	293,713	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,151,717	78,678,650	0.014638	10,936,150	160,083	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,692,805	188,386,230	0.014294	22,600,326	323,049	73.00
73.01	07301	INJECTABLE DRUGS	0	0	0.000000	0	0	73.01
74.00	07400	RENAL DIALYSIS	69,091	1,491,286	0.046330	755,277	34,992	74.00
76.00	03340	GI LAB	1,331,781	12,293,665	0.108331	599,477	64,942	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	09003	PAIN CENTER	254,676	9,701,021	0.026252	8,706	229	90.01
90.02	09001	ANTENATAL TEST CENTER	231,584	10,070,362	0.022997	9,469	218	90.02
90.03	09002	CHILD PSYCHIATRIC CLINIC	6,923	91,547	0.075622	0	0	90.03
90.04	09004	SPECIAL SURGICAL SERVICES	137,451	2,389,850	0.057514	9,843	566	90.04
90.05	09005	GENETIC SERVICES	39,785	214,185	0.185751	0	0	90.05
90.06	09006	HBP	20,911	463,177	0.045147	2,413	109	90.06
90.07	09007	MAIN	91,859	2,563,226	0.035837	11,139	399	90.07
90.08	09008	RMB	8,144	308,454	0.026403	711	19	90.08
90.09	09009	MULFORD	150,441	410,280	0.366679	1,629	597	90.09
90.10	09010	ALPINE	80,923	448,212	0.180546	1,381	249	90.10
90.11	09011	ROSCOE	113,930	443,393	0.256950	2,171	558	90.11
90.12	09012	BYRON	30,151	79,018	0.381571	516	197	90.12
90.13	09013	WINNEBAGO	41,132	266,540	0.154318	1,417	219	90.13
90.14	09014	PERRYVILLE	49,305	2,288,363	0.021546	10,580	228	90.14
90.15	09015	BELVIDERE	2,634	68,144	0.038653	308	12	90.15
90.16	09016	SPRINGBROOK	19,230	909,830	0.021136	223	5	90.16
90.17	09017	MCFARLAND	1,216	37,297	0.032603	0	0	90.17
90.18	09018	CHERRYVALLEY	30,996	170,998	0.181265	827	150	90.18
90.19	09019	KLECKNER	0	0	0.000000	0	0	90.19
90.20	09020	GALLERIA	43,850	677,688	0.064705	0	0	90.20
90.21	09021	RIVERSIDE MOB	23,825	584,963	0.040729	2,697	110	90.21
90.22	09022	MULFORD-LENOX	838	23,088	0.036296	0	0	90.22
91.00	09100	EMERGENCY	1,570,534	56,174,329	0.027958	6,473,313	180,981	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	531,163	12,686,666	0.041868	985,257	41,251	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	25,988,630	1,101,330,053		135,979,836	2,924,636	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0239

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part III
Date/Time Prepared:
4/27/2022 12:54 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	40,721	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00	
34.01	03401	NEONATAL INTENSIVE CARE	0	0	0	81,442	0	34.01	
34.02	03402	PEDIATRIC INTENSIVE CARE	0	0	0	0	0	34.02	
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00	
43.00	04300	NURSERY	0	0	0	0	0	43.00	
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00	
200.00		Total (lines 30 through 199)	0	0	0	122,163	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	40,721	37,334	1.09	10,372	30.00	
31.00	03100	INTENSIVE CARE UNIT		0	5,333	0.00	1,663	31.00	
34.01	03401	NEONATAL INTENSIVE CARE		81,442	9,653	8.44	0	34.01	
34.02	03402	PEDIATRIC INTENSIVE CARE		0	0	0.00	0	34.02	
40.00	04000	SUBPROVIDER - IPF	0	0	74	0.00	13	40.00	
43.00	04300	NURSERY		0	1,530	0.00	0	43.00	
44.00	04400	SKILLED NURSING FACILITY		0	0	0.00	0	44.00	
200.00		Total (lines 30 through 199)		122,163	53,924		12,048	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	11,305						30.00
31.00	03100	INTENSIVE CARE UNIT	0						31.00
34.01	03401	NEONATAL INTENSIVE CARE	0						34.01
34.02	03402	PEDIATRIC INTENSIVE CARE	0						34.02
40.00	04000	SUBPROVIDER - IPF	0						40.00
43.00	04300	NURSERY	0						43.00
44.00	04400	SKILLED NURSING FACILITY	0						44.00
200.00		Total (lines 30 through 199)	11,305						200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0239

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part IV
Date/Time Prepared:
4/27/2022 12:54 pm

			Title XVIII		Hospital		PPS
Cost Center Description			Non Physician Anesthetist Cost	Nursing Program Post-Stepdown Adjustments	Nursing Program	Allied Health Post-Stepdown Adjustments	Allied Health
			1.00	2A	2.00	3A	3.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	213,186
51.00	05100	RECOVERY ROOM	0	0	0	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	40,721
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	481,658
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0
56.00	05600	RADIOISOTOPE	0	0	0	0	0
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MRI	0	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	0	0	0	0	0
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	31,140
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
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
73.01	07301	INJECTABLE DRUGS	0	0	0	0	0
74.00	07400	RENAL DIALYSIS	0	0	0	0	0
76.00	03340	GI LAB	0	0	0	0	0
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0
76.99	07699	LITHOTRIPSY	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0
90.01	09003	PAIN CENTER	0	0	0	0	0
90.02	09001	ANTENATAL TEST CENTER	0	0	0	0	0
90.03	09002	CHILD PSYCHIATRIC CLINIC	0	0	0	0	0
90.04	09004	SPECIAL SURGICAL SERVICES	0	0	0	0	0
90.05	09005	GENETIC SERVICES	0	0	0	0	0
90.06	09006	HBP	0	0	0	0	0
90.07	09007	MAIN	0	0	0	0	0
90.08	09008	RMB	0	0	0	0	0
90.09	09009	MULFORD	0	0	0	0	0
90.10	09010	ALPINE	0	0	0	0	0
90.11	09011	ROSCOE	0	0	0	0	0
90.12	09012	BYRON	0	0	0	0	0
90.13	09013	WINNEBAGO	0	0	0	0	0
90.14	09014	PERRYVILLE	0	0	0	0	0
90.15	09015	BELVIDERE	0	0	0	0	0
90.16	09016	SPRINGBROOK	0	0	0	0	0
90.17	09017	MCFARLAND	0	0	0	0	0
90.18	09018	CHERRYVALLEY	0	0	0	0	0
90.19	09019	KLECKNER	0	0	0	0	0
90.20	09020	GALLERIA	0	0	0	0	0
90.21	09021	RIVERSIDE MOB	0	0	0	0	0
90.22	09022	MULFORD-LENOX	0	0	0	0	0
91.00	09100	EMERGENCY	0	0	0	0	1,125,813
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	6,323
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0
200.00		Total (lines 50 through 199)	0	0	0	0	1,898,841

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0239

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part IV
Date/Time Prepared:
4/27/2022 12:54 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	213,186	213,186	78,440,043	0.002718	50.00
51.00	05100	RECOVERY ROOM	0	0	0	7,306,862	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	40,721	40,721	16,781,916	0.002426	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	15,123,610	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	481,658	481,658	84,422,890	0.005705	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	16,878,047	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	15,121,270	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	88,818,465	0.000000	57.00
58.00	05800	MRI	0	0	0	30,234,872	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	132,130,846	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	25,324,618	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	31,140	31,140	27,673,734	0.001125	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	11,785,944	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	34,376,245	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	8,225,239	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	126,764,990	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	78,678,650	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	188,386,230	0.000000	73.00
73.01	07301	INJECTABLE DRUGS	0	0	0	0	0.000000	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	1,491,286	0.000000	74.00
76.00	03340	GI LAB	0	0	0	12,293,665	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
90.01	09003	PAIN CENTER	0	0	0	9,701,021	0.000000	90.01
90.02	09001	ANTENATAL TEST CENTER	0	0	0	10,070,362	0.000000	90.02
90.03	09002	CHILD PSYCHIATRIC CLINIC	0	0	0	91,547	0.000000	90.03
90.04	09004	SPECIAL SURGICAL SERVICES	0	0	0	2,389,850	0.000000	90.04
90.05	09005	GENETIC SERVICES	0	0	0	214,185	0.000000	90.05
90.06	09006	HBP	0	0	0	463,177	0.000000	90.06
90.07	09007	MAIN	0	0	0	2,563,226	0.000000	90.07
90.08	09008	RMB	0	0	0	308,454	0.000000	90.08
90.09	09009	MULFORD	0	0	0	410,280	0.000000	90.09
90.10	09010	ALPINE	0	0	0	448,212	0.000000	90.10
90.11	09011	ROSCOE	0	0	0	443,393	0.000000	90.11
90.12	09012	BYRON	0	0	0	79,018	0.000000	90.12
90.13	09013	WINNEBAGO	0	0	0	266,540	0.000000	90.13
90.14	09014	PERRYVILLE	0	0	0	2,288,363	0.000000	90.14
90.15	09015	BELVIDERE	0	0	0	68,144	0.000000	90.15
90.16	09016	SPRINGBROOK	0	0	0	909,830	0.000000	90.16
90.17	09017	MCFARLAND	0	0	0	37,297	0.000000	90.17
90.18	09018	CHERRYVALLEY	0	0	0	170,998	0.000000	90.18
90.19	09019	KLECKNER	0	0	0	0	0.000000	90.19
90.20	09020	GALLERIA	0	0	0	677,688	0.000000	90.20
90.21	09021	RIVERSIDE MOB	0	0	0	584,963	0.000000	90.21
90.22	09022	MULFORD-LENOX	0	0	0	23,088	0.000000	90.22
91.00	09100	EMERGENCY	0	1,125,813	1,125,813	56,174,329	0.020041	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	6,323	6,323	12,686,666	0.000498	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0.000000	95.00
200.00	Total (lines 50 through 199)		0	1,898,841	1,898,841	1,101,330,053		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0239

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part IV
Date/Time Prepared:
4/27/2022 12:54 pm

				Title XVIII		Hospital	PPS	
Cost Center Description			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.002718	8,636,913	23,475	8,687,813	23,613	50.00
51.00	05100	RECOVERY ROOM	0.000000	833,644	0	702,090	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.002426	44,921	109	15,339	37	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	1,486,876	0	1,646,621	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.005705	13,483,476	76,923	9,371,011	53,462	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	39,738	0	4,912,259	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	809,371	0	3,958,141	0	56.00
57.00	05700	CT SCAN	0.000000	10,217,156	0	13,148,907	0	57.00
58.00	05800	MRI	0.000000	2,285,874	0	4,709,221	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	18,481,263	0	7,267,839	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	159,395	0	4,067,788	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.001125	6,663,155	7,496	395,501	445	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	3,062,293	0	42,737	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	4,825,936	0	4,801,051	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	397,350	0	1,125,992	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	22,138,645	0	12,090,854	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	10,936,150	0	9,727,173	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	22,600,326	0	33,215,949	0	73.00
73.01	07301	INJECTABLE DRUGS	0.000000	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0.000000	755,277	0	23,330	0	74.00
76.00	03340	GI LAB	0.000000	599,477	0	1,988,898	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09003	PAIN CENTER	0.000000	8,706	0	2,768,172	0	90.01
90.02	09001	ANTENATAL TEST CENTER	0.000000	9,469	0	29,716	0	90.02
90.03	09002	CHILD PSYCHIATRIC CLINIC	0.000000	0	0	0	0	90.03
90.04	09004	SPECIAL SURGICAL SERVICES	0.000000	9,843	0	886,381	0	90.04
90.05	09005	GENETIC SERVICES	0.000000	0	0	6,146	0	90.05
90.06	09006	HBP	0.000000	2,413	0	124,336	0	90.06
90.07	09007	MAIN	0.000000	11,139	0	795,710	0	90.07
90.08	09008	RMB	0.000000	711	0	167,570	0	90.08
90.09	09009	MULFORD	0.000000	1,629	0	148,657	0	90.09
90.10	09010	ALPINE	0.000000	1,381	0	163,826	0	90.10
90.11	09011	ROSCOE	0.000000	2,171	0	125,009	0	90.11
90.12	09012	BYRON	0.000000	516	0	30,039	0	90.12
90.13	09013	WINNEBAGO	0.000000	1,417	0	112,625	0	90.13
90.14	09014	PERRYVILLE	0.000000	10,580	0	679,136	0	90.14
90.15	09015	BELVIDERE	0.000000	308	0	21,007	0	90.15
90.16	09016	SPRINGBROOK	0.000000	223	0	214,601	0	90.16
90.17	09017	MCFARLAND	0.000000	0	0	12,932	0	90.17
90.18	09018	CHERRYVALLEY	0.000000	827	0	49,689	0	90.18
90.19	09019	KLECKNER	0.000000	0	0	0	0	90.19
90.20	09020	GALLERIA	0.000000	0	0	192,285	0	90.20
90.21	09021	RIVERSIDE MOB	0.000000	2,697	0	182,383	0	90.21
90.22	09022	MULFORD-LENOX	0.000000	0	0	7,653	0	90.22
91.00	09100	EMERGENCY	0.020041	6,473,313	129,732	5,105,982	102,329	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000498	985,257	491	1,911,204	952	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		135,979,836	238,226	135,633,573	180,838	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0239

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part V
Date/Time Prepared:
4/27/2022 12:54 pm

				Title XVIII		Hospital		PPS	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		PPS Services (see inst.)	
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
			1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0.367038	8,687,813	0	0	3,188,758	50.00	
51.00	05100	RECOVERY ROOM	0.260538	702,090	0	0	182,921	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.351356	15,339	0	0	5,389	52.00	
53.00	05300	ANESTHESIOLOGY	0.092149	1,646,621	0	0	151,734	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.142086	9,371,011	0	0	1,331,489	54.00	
55.00	05500	RADIOLOGY-THERAPEUTIC	0.178252	4,912,259	0	0	875,620	55.00	
56.00	05600	RADIOISOTOPE	0.109700	3,958,141	0	0	434,208	56.00	
57.00	05700	CT SCAN	0.038151	13,148,907	0	0	501,644	57.00	
58.00	05800	MRI	0.081140	4,709,221	0	0	382,106	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00	
60.00	06000	LABORATORY	0.127961	7,267,839	0	0	930,000	60.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30	
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00	
64.00	06400	INTRAVENOUS THERAPY	0.026121	4,067,788	0	0	106,255	64.00	
65.00	06500	RESPIRATORY THERAPY	0.165961	395,501	0	0	65,638	65.00	
66.00	06600	PHYSICAL THERAPY	0.244232	42,737	0	0	10,438	66.00	
69.00	06900	ELECTROCARDIOLOGY	0.079449	4,801,051	0	0	381,439	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0.179251	1,125,992	0	0	201,835	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.154888	12,090,854	0	0	1,872,728	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.170809	9,727,173	0	0	1,661,489	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.146891	33,215,949	8,921	530,229	4,879,124	73.00	
73.01	07301	INJECTABLE DRUGS	0.000000	0	0	0	0	73.01	
74.00	07400	RENAL DIALYSIS	0.634556	23,330	0	0	14,804	74.00	
76.00	03340	GI LAB	0.285671	1,988,898	0	0	568,170	76.00	
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98	
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99	
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00	
90.01	09003	PAIN CENTER	0.152743	2,768,172	0	0	422,819	90.01	
90.02	09001	ANTENATAL TEST CENTER	0.140857	29,716	0	0	4,186	90.02	
90.03	09002	CHILD PSYCHIATRIC CLINIC	0.788480	0	0	0	0	90.03	
90.04	09004	SPECIAL SURGICAL SERVICES	0.353363	886,381	0	0	313,214	90.04	
90.05	09005	GENETIC SERVICES	2.272573	6,146	0	0	13,967	90.05	
90.06	09006	HBP	0.728197	124,336	0	0	90,541	90.06	
90.07	09007	MAIN	0.577992	795,710	0	0	459,914	90.07	
90.08	09008	RMB	0.425739	167,570	0	0	71,341	90.08	
90.09	09009	MULFORD	2.190026	148,657	0	0	325,563	90.09	
90.10	09010	ALPINE	1.185789	163,826	0	0	194,263	90.10	
90.11	09011	ROSCOE	1.549950	125,009	0	0	193,758	90.11	
90.12	09012	BYRON	2.297477	30,039	0	0	69,014	90.12	
90.13	09013	WINNEBAGO	1.144241	112,625	0	0	128,870	90.13	
90.14	09014	PERRYVILLE	0.347416	679,136	0	0	235,943	90.14	
90.15	09015	BELVIDERE	0.623591	21,007	0	0	13,100	90.15	
90.16	09016	SPRINGBROOK	0.340797	214,601	0	0	73,135	90.16	
90.17	09017	MCFARLAND	0.525672	12,932	0	0	6,798	90.17	
90.18	09018	CHERRYVALLEY	1.219611	49,689	0	0	60,601	90.18	
90.19	09019	KLECKNER	0.000000	0	0	0	0	90.19	
90.20	09020	GALLERIA	0.489070	192,285	0	0	94,041	90.20	
90.21	09021	RIVERSIDE MOB	0.656929	182,383	0	0	119,813	90.21	
90.22	09022	MULFORD-LENOX	0.585023	7,653	0	0	4,477	90.22	
91.00	09100	EMERGENCY	0.245665	5,105,982	0	0	1,254,361	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.436055	1,911,204	0	0	833,390	92.00	
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES	0.000000		0			95.00	
200.00		Subtotal (see instructions)		135,633,573	8,921	530,229	22,728,898	200.00	
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00	
202.00		Net Charges (line 200 - line 201)		135,633,573	8,921	530,229	22,728,898	202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0239

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part V
Date/Time Prepared:
4/27/2022 12:54 pm

			Title XVIII		Hospital	PPS
	Cost Center Description		Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
56.00	05600	RADIOISOTOPE	0	0		56.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
64.00	06400	INTRAVENOUS THERAPY	0	0		64.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,310	77,886		73.00
73.01	07301	INJECTABLE DRUGS	0	0		73.01
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03340	GI LAB	0	0		76.00
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0		76.99
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0		90.00
90.01	09003	PAIN CENTER	0	0		90.01
90.02	09001	ANTENATAL TEST CENTER	0	0		90.02
90.03	09002	CHILD PSYCHIATRIC CLINIC	0	0		90.03
90.04	09004	SPECIAL SURGICAL SERVICES	0	0		90.04
90.05	09005	GENETIC SERVICES	0	0		90.05
90.06	09006	HBP	0	0		90.06
90.07	09007	MAIN	0	0		90.07
90.08	09008	RMB	0	0		90.08
90.09	09009	MULFORD	0	0		90.09
90.10	09010	ALPINE	0	0		90.10
90.11	09011	ROSCOE	0	0		90.11
90.12	09012	BYRON	0	0		90.12
90.13	09013	WINNEBAGO	0	0		90.13
90.14	09014	PERRYVILLE	0	0		90.14
90.15	09015	BELVIDERE	0	0		90.15
90.16	09016	SPRINGBROOK	0	0		90.16
90.17	09017	MCFARLAND	0	0		90.17
90.18	09018	CHERRYVALLEY	0	0		90.18
90.19	09019	KLECKNER	0	0		90.19
90.20	09020	GALLERIA	0	0		90.20
90.21	09021	RIVERSIDE MOB	0	0		90.21
90.22	09022	MULFORD-LENOX	0	0		90.22
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0			95.00
200.00		Subtotal (see instructions)	1,310	77,886		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	1,310	77,886		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0239

Period:

Worksheet D

Component CCN: 14-S239

From 07/01/2020
To 06/30/2021Part II
Date/Time Prepared:
4/27/2022 12:54 pm

Title XVIII				Subprovider - IPF	PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)
		1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	4,917,606	78,440,043	0.062693	0	0 50.00
51.00	05100 RECOVERY ROOM	194,460	7,306,862	0.026613	0	0 51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	683,557	16,781,916	0.040732	0	0 52.00
53.00	05300 ANESTHESIOLOGY	184,578	15,123,610	0.012205	0	0 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	3,284,449	84,422,890	0.038905	2,937	114 54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	734,957	16,878,047	0.043545	0	0 55.00
56.00	05600 RADIOISOTOPE	328,524	15,121,270	0.021726	0	0 56.00
57.00	05700 CT SCAN	968,698	88,818,465	0.010906	3,292	36 57.00
58.00	05800 MRI	973,810	30,234,872	0.032208	0	0 58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000	0	0 59.00
60.00	06000 LABORATORY	1,941,388	132,130,846	0.014693	6,133	90 60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0 62.30
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000	0	0 63.00
64.00	06400 INTRAVENOUS THERAPY	44,574	25,324,618	0.001760	0	0 64.00
65.00	06500 RESPIRATORY THERAPY	535,281	27,673,734	0.019343	9,675	187 65.00
66.00	06600 PHYSICAL THERAPY	198,105	11,785,944	0.016809	0	0 66.00
69.00	06900 ELECTROCARDIOLOGY	309,478	34,376,245	0.009003	721	6 69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	280,486	8,225,239	0.034101	0	0 70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1,681,784	126,764,990	0.013267	992	13 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1,151,717	78,678,650	0.014638	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	2,692,805	188,386,230	0.014294	9,254	132 73.00
73.01	07301 INJECTABLE DRUGS	0	0	0.000000	0	0 73.01
74.00	07400 RENAL DIALYSIS	69,091	1,491,286	0.046330	0	0 74.00
76.00	03340 GI LAB	1,331,781	12,293,665	0.108331	0	0 76.00
76.97	07697 CARDIAC REHABILITATION	0	0	0.000000	0	0 76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0 76.98
76.99	07699 LITHOTRIPSY	0	0	0.000000	0	0 76.99
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	0	0.000000	0	0 90.00
90.01	09003 PAIN CENTER	254,676	9,701,021	0.026252	0	0 90.01
90.02	09001 ANTENATAL TEST CENTER	231,584	10,070,362	0.022997	0	0 90.02
90.03	09002 CHILD PSYCHIATRIC CLINIC	6,923	91,547	0.075622	0	0 90.03
90.04	09004 SPECIAL SURGICAL SERVICES	137,451	2,389,850	0.057514	0	0 90.04
90.05	09005 GENETIC SERVICES	39,785	214,185	0.185751	0	0 90.05
90.06	09006 HBP	20,911	463,177	0.045147	0	0 90.06
90.07	09007 MAIN	91,859	2,563,226	0.035837	0	0 90.07
90.08	09008 RMB	8,144	308,454	0.026403	0	0 90.08
90.09	09009 MULFORD	150,441	410,280	0.366679	0	0 90.09
90.10	09010 ALPINE	80,923	448,212	0.180546	0	0 90.10
90.11	09011 ROSCOE	113,930	443,393	0.256950	0	0 90.11
90.12	09012 BYRON	30,151	79,018	0.381571	0	0 90.12
90.13	09013 WINNEBAGO	41,132	266,540	0.154318	0	0 90.13
90.14	09014 PERRYVILLE	49,305	2,288,363	0.021546	0	0 90.14
90.15	09015 BELVIDERE	2,634	68,144	0.038653	0	0 90.15
90.16	09016 SPRINGBROOK	19,230	909,830	0.021136	0	0 90.16
90.17	09017 MCFARLAND	1,216	37,297	0.032603	0	0 90.17
90.18	09018 CHERRYVALLEY	30,996	170,998	0.181265	0	0 90.18
90.19	09019 KLECKNER	0	0	0.000000	0	0 90.19
90.20	09020 GALLERIA	43,850	677,688	0.064705	0	0 90.20
90.21	09021 RIVERSIDE MOB	23,825	584,963	0.040729	0	0 90.21
90.22	09022 MULFORD-LENOX	838	23,088	0.036296	0	0 90.22
91.00	09100 EMERGENCY	1,570,534	56,174,329	0.027958	6,507	182 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	12,686,666	0.000000	0	0 92.00
OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES					95.00
200.00	Total (lines 50 through 199)	25,457,467	1,101,330,053		39,511	760 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0239 Component CCN: 14-S239		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part IV Date/Time Prepared: 4/27/2022 12:54 pm	
				Title XVIII		Subprovider - IPF		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	213,186	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	40,721	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	481,658	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC		0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE		0	0	0	0	0	56.00
57.00	05700	CT SCAN		0	0	0	0	0	57.00
58.00	05800	MRI		0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	0	0	59.00
60.00	06000	LABORATORY		0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS		0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.		0	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY		0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	0	31,140	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	0	73.00
73.01	07301	INJECTABLE DRUGS		0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS		0	0	0	0	0	74.00
76.00	03340	GI LAB		0	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION		0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY		0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	0	0	90.00
90.01	09003	PAIN CENTER		0	0	0	0	0	90.01
90.02	09001	ANTENATAL TEST CENTER		0	0	0	0	0	90.02
90.03	09002	CHILD PSYCHIATRIC CLINIC		0	0	0	0	0	90.03
90.04	09004	SPECIAL SURGICAL SERVICES		0	0	0	0	0	90.04
90.05	09005	GENETIC SERVICES		0	0	0	0	0	90.05
90.06	09006	HBP		0	0	0	0	0	90.06
90.07	09007	MAIN		0	0	0	0	0	90.07
90.08	09008	RMB		0	0	0	0	0	90.08
90.09	09009	MULFORD		0	0	0	0	0	90.09
90.10	09010	ALPINE		0	0	0	0	0	90.10
90.11	09011	ROSCOE		0	0	0	0	0	90.11
90.12	09012	BYRON		0	0	0	0	0	90.12
90.13	09013	WINNEBAGO		0	0	0	0	0	90.13
90.14	09014	PERRYVILLE		0	0	0	0	0	90.14
90.15	09015	BELVIDERE		0	0	0	0	0	90.15
90.16	09016	SPRINGBROOK		0	0	0	0	0	90.16
90.17	09017	MCFARLAND		0	0	0	0	0	90.17
90.18	09018	CHERRYVALLEY		0	0	0	0	0	90.18
90.19	09019	KLECKNER		0	0	0	0	0	90.19
90.20	09020	GALLERIA		0	0	0	0	0	90.20
90.21	09021	RIVERSIDE MOB		0	0	0	0	0	90.21
90.22	09022	MULFORD-LENOX		0	0	0	0	0	90.22
91.00	09100	EMERGENCY		0	0	0	0	1,125,813	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES		0	0	0	0	0	95.00
200.00		Total (lines 50 through 199)		0	0	0	0	1,892,518	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0239 Component CCN: 14-S239		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part IV Date/Time Prepared: 4/27/2022 12:54 pm	
			Title XVIII		Subprovider - IPF		PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	213,186	213,186	78,440,043	0.002718	50.00
51.00	05100	RECOVERY ROOM	0	0	0	7,306,862	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	40,721	40,721	16,781,916	0.002426	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	15,123,610	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	481,658	481,658	84,422,890	0.005705	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	16,878,047	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	15,121,270	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	88,818,465	0.000000	57.00
58.00	05800	MRI	0	0	0	30,234,872	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	132,130,846	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	25,324,618	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	31,140	31,140	27,673,734	0.001125	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	11,785,944	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	34,376,245	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	8,225,239	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	126,764,990	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	78,678,650	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	188,386,230	0.000000	73.00
73.01	07301	INJECTABLE DRUGS	0	0	0	0	0.000000	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	1,491,286	0.000000	74.00
76.00	03340	GI LAB	0	0	0	12,293,665	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
90.01	09003	PAIN CENTER	0	0	0	9,701,021	0.000000	90.01
90.02	09001	ANTENATAL TEST CENTER	0	0	0	10,070,362	0.000000	90.02
90.03	09002	CHILD PSYCHIATRIC CLINIC	0	0	0	91,547	0.000000	90.03
90.04	09004	SPECIAL SURGICAL SERVICES	0	0	0	2,389,850	0.000000	90.04
90.05	09005	GENETIC SERVICES	0	0	0	214,185	0.000000	90.05
90.06	09006	HBP	0	0	0	463,177	0.000000	90.06
90.07	09007	MAIN	0	0	0	2,563,226	0.000000	90.07
90.08	09008	RMB	0	0	0	308,454	0.000000	90.08
90.09	09009	MULFORD	0	0	0	410,280	0.000000	90.09
90.10	09010	ALPINE	0	0	0	448,212	0.000000	90.10
90.11	09011	ROSCOE	0	0	0	443,393	0.000000	90.11
90.12	09012	BYRON	0	0	0	79,018	0.000000	90.12
90.13	09013	WINNEBAGO	0	0	0	266,540	0.000000	90.13
90.14	09014	PERRYVILLE	0	0	0	2,288,363	0.000000	90.14
90.15	09015	BELVIDERE	0	0	0	68,144	0.000000	90.15
90.16	09016	SPRINGBROOK	0	0	0	909,830	0.000000	90.16
90.17	09017	MCFARLAND	0	0	0	37,297	0.000000	90.17
90.18	09018	CHERRYVALLEY	0	0	0	170,998	0.000000	90.18
90.19	09019	KLECKNER	0	0	0	0	0.000000	90.19
90.20	09020	GALLERIA	0	0	0	677,688	0.000000	90.20
90.21	09021	RIVERSIDE MOB	0	0	0	584,963	0.000000	90.21
90.22	09022	MULFORD-LENOX	0	0	0	23,088	0.000000	90.22
91.00	09100	EMERGENCY	0	1,125,813	1,125,813	56,174,329	0.020041	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	12,686,666	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	1,892,518	1,892,518	1,101,330,053		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0239

Period:

Worksheet D

Component CCN: 14-S239

From 07/01/2020
To 06/30/2021Part IV
Date/Time Prepared:
4/27/2022 12:54 pm

Title XVIII				Subprovider - IPF		PPS	
Cost Center Description		Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0.002718	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	0.002426	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.005705	2,937	17	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
56.00	05600 RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700 CT SCAN	0.000000	3,292	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	6,133	0	0	0	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.001125	9,675	11	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	721	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	992	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	9,254	0	0	0	73.00
73.01	07301 INJECTABLE DRUGS	0.000000	0	0	0	0	73.01
74.00	07400 RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00	03340 GI LAB	0.000000	0	0	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699 LITHOTRIPSY	0.000000	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0.000000	0	0	0	0	90.00
90.01	09003 PAIN CENTER	0.000000	0	0	0	0	90.01
90.02	09001 ANTENATAL TEST CENTER	0.000000	0	0	0	0	90.02
90.03	09002 CHILD PSYCHIATRIC CLINIC	0.000000	0	0	0	0	90.03
90.04	09004 SPECIAL SURGICAL SERVICES	0.000000	0	0	0	0	90.04
90.05	09005 GENETIC SERVICES	0.000000	0	0	0	0	90.05
90.06	09006 HBP	0.000000	0	0	0	0	90.06
90.07	09007 MAIN	0.000000	0	0	0	0	90.07
90.08	09008 RMB	0.000000	0	0	0	0	90.08
90.09	09009 MULFORD	0.000000	0	0	0	0	90.09
90.10	09010 ALPINE	0.000000	0	0	0	0	90.10
90.11	09011 ROSCOE	0.000000	0	0	0	0	90.11
90.12	09012 BYRON	0.000000	0	0	0	0	90.12
90.13	09013 WINNEBAGO	0.000000	0	0	0	0	90.13
90.14	09014 PERRYVILLE	0.000000	0	0	0	0	90.14
90.15	09015 BELVIDERE	0.000000	0	0	0	0	90.15
90.16	09016 SPRINGBROOK	0.000000	0	0	0	0	90.16
90.17	09017 MCFARLAND	0.000000	0	0	0	0	90.17
90.18	09018 CHERRYVALLEY	0.000000	0	0	0	0	90.18
90.19	09019 KLECKNER	0.000000	0	0	0	0	90.19
90.20	09020 GALLERIA	0.000000	0	0	0	0	90.20
90.21	09021 RIVERSIDE MOB	0.000000	0	0	0	0	90.21
90.22	09022 MULFORD-LENOX	0.000000	0	0	0	0	90.22
91.00	09100 EMERGENCY	0.020041	6,507	130	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)		39,511	158	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0239

Period:

Worksheet D

Component CCN: 14-S239

From 07/01/2020
To 06/30/2021Part V
Date/Time Prepared:
4/27/2022 12:54 pm

Title XVIII

Subprovider -
IPF

PPS

Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs	
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)
		1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.367038	0	0	0
51.00	05100	RECOVERY ROOM	0.260538	0	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.351356	0	0	0
53.00	05300	ANESTHESIOLOGY	0.092149	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.142086	0	0	0
55.00	05500	RADIOLOGY-THERAPEUTIC	0.178252	0	0	0
56.00	05600	RADIOISOTOPE	0.109700	0	0	0
57.00	05700	CT SCAN	0.038151	0	0	0
58.00	05800	MRI	0.081140	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0
60.00	06000	LABORATORY	0.127961	0	0	0
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0
64.00	06400	INTRAVENOUS THERAPY	0.026121	0	0	0
65.00	06500	RESPIRATORY THERAPY	0.165961	0	0	0
66.00	06600	PHYSICAL THERAPY	0.244232	0	0	0
69.00	06900	ELECTROCARDIOLOGY	0.079449	0	0	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0.179251	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.154888	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.170809	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0.146891	0	0	0
73.01	07301	INJECTABLE DRUGS	0.000000	0	0	0
74.00	07400	RENAL DIALYSIS	0.634556	0	0	0
76.00	03340	GI LAB	0.285671	0	0	0
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0
76.99	07699	LITHOTRIPSY	0.000000	0	0	0
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0
90.01	09003	PAIN CENTER	0.152743	0	0	0
90.02	09001	ANTENATAL TEST CENTER	0.140857	0	0	0
90.03	09002	CHILD PSYCHIATRIC CLINIC	0.788480	0	0	0
90.04	09004	SPECIAL SURGICAL SERVICES	0.353363	0	0	0
90.05	09005	GENETIC SERVICES	2.272573	0	0	0
90.06	09006	HBP	0.728197	0	0	0
90.07	09007	MAIN	0.577992	0	0	0
90.08	09008	RMB	0.425739	0	0	0
90.09	09009	MULFORD	2.190026	0	0	0
90.10	09010	ALPINE	1.185789	0	0	0
90.11	09011	ROSCOE	1.549950	0	0	0
90.12	09012	BYRON	2.297477	0	0	0
90.13	09013	WINNEBAGO	1.144241	0	0	0
90.14	09014	PERRYVILLE	0.347416	0	0	0
90.15	09015	BELVIDERE	0.623591	0	0	0
90.16	09016	SPRINGBROOK	0.340797	0	0	0
90.17	09017	MCFARLAND	0.525672	0	0	0
90.18	09018	CHERRYVALLEY	1.219611	0	0	0
90.19	09019	KLECKNER	0.000000	0	0	0
90.20	09020	GALLERIA	0.489070	0	0	0
90.21	09021	RIVERSIDE MOB	0.656929	0	0	0
90.22	09022	MULFORD-LENOX	0.585023	0	0	0
91.00	09100	EMERGENCY	0.245665	0	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.436055	0	0	0
OTHER REIMBURSABLE COST CENTERS						
95.00	09500	AMBULANCE SERVICES	0.000000	0	0	0
200.00		Subtotal (see instructions)		0	0	0
201.00		Less PBP Clinic Lab. Services-Program Only Charges		0	0	0
202.00		Net Charges (line 200 - line 201)		0	0	0

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0239

Period:

Worksheet D

Component CCN: 14-S239

From 07/01/2020
To 06/30/2021Part V
Date/Time Prepared:
4/27/2022 12:54 pm

Title XVIII

Subprovider -
IPF

PPS

	Cost Center Description	Costs			
		Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
		6.00	7.00		
	ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
73.01	07301	INJECTABLE DRUGS	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03340	GI LAB	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
	OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0	90.00
90.01	09003	PAIN CENTER	0	0	90.01
90.02	09001	ANTENATAL TEST CENTER	0	0	90.02
90.03	09002	CHILD PSYCHIATRIC CLINIC	0	0	90.03
90.04	09004	SPECIAL SURGICAL SERVICES	0	0	90.04
90.05	09005	GENETIC SERVICES	0	0	90.05
90.06	09006	HBP	0	0	90.06
90.07	09007	MAIN	0	0	90.07
90.08	09008	RMB	0	0	90.08
90.09	09009	MULFORD	0	0	90.09
90.10	09010	ALPINE	0	0	90.10
90.11	09011	ROSCOE	0	0	90.11
90.12	09012	BYRON	0	0	90.12
90.13	09013	WINNEBAGO	0	0	90.13
90.14	09014	PERRYVILLE	0	0	90.14
90.15	09015	BELVIDERE	0	0	90.15
90.16	09016	SPRINGBROOK	0	0	90.16
90.17	09017	MCFARLAND	0	0	90.17
90.18	09018	CHERRYVALLEY	0	0	90.18
90.19	09019	KLECKNER	0	0	90.19
90.20	09020	GALLERIA	0	0	90.20
90.21	09021	RIVERSIDE MOB	0	0	90.21
90.22	09022	MULFORD-LENOX	0	0	90.22
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS				
95.00	09500	AMBULANCE SERVICES	0		95.00
200.00		Subtotal (see instructions)	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	0	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0239

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part I
Date/Time Prepared:
4/27/2022 12:54 pm

			Title XIX		Hospital	Cost		
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)		
		1.00	2.00	3.00	4.00	5.00		
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	3,421,990	0	3,421,990	37,334	91.66	30.00	
31.00	INTENSIVE CARE UNIT	1,053,999		1,053,999	5,333	197.64	31.00	
34.01	NEONATAL INTENSIVE CARE	1,275,405		1,275,405	9,653	132.13	34.01	
34.02	PEDIATRIC INTENSIVE CARE	3,326		3,326	0	0.00	34.02	
40.00	SUBPROVIDER - IPF	119,326	0	119,326	74	1,612.51	40.00	
43.00	NURSERY	479,180		479,180	1,530	313.19	43.00	
44.00	SKILLED NURSING FACILITY	22,484		22,484	0	0.00	44.00	
200.00	Total (lines 30 through 199)	6,375,710		6,375,710	53,924		200.00	
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)					
		6.00	7.00					
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	2,562	234,833					30.00
31.00	INTENSIVE CARE UNIT	438	86,566					31.00
34.01	NEONATAL INTENSIVE CARE	2,258	298,350					34.01
34.02	PEDIATRIC INTENSIVE CARE	0	0					34.02
40.00	SUBPROVIDER - IPF	11	17,738					40.00
43.00	NURSERY	458	143,441					43.00
44.00	SKILLED NURSING FACILITY	0	0					44.00
200.00	Total (lines 30 through 199)	5,727	780,928					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0239

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part II
Date/Time Prepared:
4/27/2022 12:54 pm

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	Cost
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	4,917,606	0	0.000000	0	0	50.00
51.00	05100 RECOVERY ROOM	194,460	0	0.000000	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	683,557	0	0.000000	0	0	52.00
53.00	05300 ANESTHESIOLOGY	184,578	0	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	3,284,449	0	0.000000	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	734,957	0	0.000000	0	0	55.00
56.00	05600 RADIOISOTOPE	328,524	0	0.000000	0	0	56.00
57.00	05700 CT SCAN	968,698	0	0.000000	0	0	57.00
58.00	05800 MRI	973,810	0	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000 LABORATORY	1,941,388	0	0.000000	0	0	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	44,574	0	0.000000	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	535,281	0	0.000000	0	0	65.00
66.00	06600 PHYSICAL THERAPY	198,105	0	0.000000	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	309,478	0	0.000000	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	280,486	0	0.000000	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1,681,784	0	0.000000	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1,151,717	0	0.000000	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	2,692,805	0	0.000000	0	0	73.00
73.01	07301 INJECTABLE DRUGS	0	0	0.000000	0	0	73.01
74.00	07400 RENAL DIALYSIS	69,091	0	0.000000	0	0	74.00
76.00	03340 GI LAB	1,331,781	0	0.000000	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699 LITHOTRIPSY	0	0	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	0	0.000000	0	0	90.00
90.01	09003 PAIN CENTER	254,676	0	0.000000	0	0	90.01
90.02	09001 ANTENATAL TEST CENTER	231,584	0	0.000000	0	0	90.02
90.03	09002 CHILD PSYCHIATRIC CLINIC	6,923	0	0.000000	0	0	90.03
90.04	09004 SPECIAL SURGICAL SERVICES	137,451	0	0.000000	0	0	90.04
90.05	09005 GENETIC SERVICES	39,785	0	0.000000	0	0	90.05
90.06	09006 HBP	20,911	0	0.000000	0	0	90.06
90.07	09007 MAIN	91,859	0	0.000000	0	0	90.07
90.08	09008 RMB	8,144	0	0.000000	0	0	90.08
90.09	09009 MULFORD	150,441	0	0.000000	0	0	90.09
90.10	09010 ALPINE	80,923	0	0.000000	0	0	90.10
90.11	09011 ROSCOE	113,930	0	0.000000	0	0	90.11
90.12	09012 BYRON	30,151	0	0.000000	0	0	90.12
90.13	09013 WINNEBAGO	41,132	0	0.000000	0	0	90.13
90.14	09014 PERRYVILLE	49,305	0	0.000000	0	0	90.14
90.15	09015 BELVIDERE	2,634	0	0.000000	0	0	90.15
90.16	09016 SPRINGBROOK	19,230	0	0.000000	0	0	90.16
90.17	09017 MCFARLAND	1,216	0	0.000000	0	0	90.17
90.18	09018 CHERRYVALLEY	30,996	0	0.000000	0	0	90.18
90.19	09019 KLECKNER	0	0	0.000000	0	0	90.19
90.20	09020 GALLERIA	43,850	0	0.000000	0	0	90.20
90.21	09021 RIVERSIDE MOB	23,825	0	0.000000	0	0	90.21
90.22	09022 MULFORD-LENOX	838	0	0.000000	0	0	90.22
91.00	09100 EMERGENCY	1,570,534	0	0.000000	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	531,162	0	0.000000	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES						95.00
200.00	Total (lines 50 through 199)	25,988,629	0		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0239

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part III
Date/Time Prepared:
4/27/2022 12:54 pm

				Title XIX		Hospital	Cost	
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	40,721	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
34.01	03401	NEONATAL INTENSIVE CARE	0	0	0	81,442	0	34.01
34.02	03402	PEDIATRIC INTENSIVE CARE	0	0	0	0	0	34.02
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
200.00		Total (lines 30 through 199)	0	0	0	122,163	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	40,721	37,334	1.09	2,562	30.00
31.00	03100	INTENSIVE CARE UNIT		0	5,333	0.00	438	31.00
34.01	03401	NEONATAL INTENSIVE CARE		81,442	9,653	8.44	2,258	34.01
34.02	03402	PEDIATRIC INTENSIVE CARE		0	0	0.00	0	34.02
40.00	04000	SUBPROVIDER - IPF	0	0	74	0.00	11	40.00
43.00	04300	NURSERY		0	1,530	0.00	458	43.00
44.00	04400	SKILLED NURSING FACILITY		0	0	0.00	0	44.00
200.00		Total (lines 30 through 199)		122,163	53,924		5,727	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	2,793					
31.00	03100	INTENSIVE CARE UNIT	0					
34.01	03401	NEONATAL INTENSIVE CARE	19,058					
34.02	03402	PEDIATRIC INTENSIVE CARE	0					
40.00	04000	SUBPROVIDER - IPF	0					
43.00	04300	NURSERY	0					
44.00	04400	SKILLED NURSING FACILITY	0					
200.00		Total (lines 30 through 199)	21,851					

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0239

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part IV
Date/Time Prepared:
4/27/2022 12:54 pm

Cost Center Description			Title XIX		Hospital		Cost
			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	213,186
51.00	05100	RECOVERY ROOM	0	0	0	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	40,721
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	481,658
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0
56.00	05600	RADIOISOTOPE	0	0	0	0	0
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MRI	0	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	0	0	0	0	0
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	31,140
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0
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
73.01	07301	INJECTABLE DRUGS	0	0	0	0	0
74.00	07400	RENAL DIALYSIS	0	0	0	0	0
76.00	03340	GI LAB	0	0	0	0	0
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0
76.99	07699	LITHOTRIPSY	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0
90.01	09003	PAIN CENTER	0	0	0	0	0
90.02	09001	ANTENATAL TEST CENTER	0	0	0	0	0
90.03	09002	CHILD PSYCHIATRIC CLINIC	0	0	0	0	0
90.04	09004	SPECIAL SURGICAL SERVICES	0	0	0	0	0
90.05	09005	GENETIC SERVICES	0	0	0	0	0
90.06	09006	HBP	0	0	0	0	0
90.07	09007	MAIN	0	0	0	0	0
90.08	09008	RMB	0	0	0	0	0
90.09	09009	MULFORD	0	0	0	0	0
90.10	09010	ALPINE	0	0	0	0	0
90.11	09011	ROSCOE	0	0	0	0	0
90.12	09012	BYRON	0	0	0	0	0
90.13	09013	WINNEBAGO	0	0	0	0	0
90.14	09014	PERRYVILLE	0	0	0	0	0
90.15	09015	BELVIDERE	0	0	0	0	0
90.16	09016	SPRINGBROOK	0	0	0	0	0
90.17	09017	MCFARLAND	0	0	0	0	0
90.18	09018	CHERRYVALLEY	0	0	0	0	0
90.19	09019	KLECKNER	0	0	0	0	0
90.20	09020	GALLERIA	0	0	0	0	0
90.21	09021	RIVERSIDE MOB	0	0	0	0	0
90.22	09022	MULFORD-LENOX	0	0	0	0	0
91.00	09100	EMERGENCY	0	0	0	0	1,125,813
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	6,322
OTHER REIMBURSABLE COST CENTERS							
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0
200.00		Total (lines 50 through 199)	0	0	0	0	1,898,840

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0239

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part IV
Date/Time Prepared:
4/27/2022 12:54 pm

				Title XIX		Hospital	Cost	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	213,186	213,186	0	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	40,721	40,721	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	481,658	481,658	0	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0.000000	56.00
57.00	05700	CT SCAN	0	0	0	0	0.000000	57.00
58.00	05800	MRI	0	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	0	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0	31,140	31,140	0	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0.000000	73.00
73.01	07301	INJECTABLE DRUGS	0	0	0	0	0.000000	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0.000000	74.00
76.00	03340	GI LAB	0	0	0	0	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0.000000	90.00
90.01	09003	PAIN CENTER	0	0	0	0	0.000000	90.01
90.02	09001	ANTENATAL TEST CENTER	0	0	0	0	0.000000	90.02
90.03	09002	CHILD PSYCHIATRIC CLINIC	0	0	0	0	0.000000	90.03
90.04	09004	SPECIAL SURGICAL SERVICES	0	0	0	0	0.000000	90.04
90.05	09005	GENETIC SERVICES	0	0	0	0	0.000000	90.05
90.06	09006	HBP	0	0	0	0	0.000000	90.06
90.07	09007	MAIN	0	0	0	0	0.000000	90.07
90.08	09008	RMB	0	0	0	0	0.000000	90.08
90.09	09009	MULFORD	0	0	0	0	0.000000	90.09
90.10	09010	ALPINE	0	0	0	0	0.000000	90.10
90.11	09011	ROSCOE	0	0	0	0	0.000000	90.11
90.12	09012	BYRON	0	0	0	0	0.000000	90.12
90.13	09013	WINNEBAGO	0	0	0	0	0.000000	90.13
90.14	09014	PERRYVILLE	0	0	0	0	0.000000	90.14
90.15	09015	BELVIDERE	0	0	0	0	0.000000	90.15
90.16	09016	SPRINGBROOK	0	0	0	0	0.000000	90.16
90.17	09017	MCFARLAND	0	0	0	0	0.000000	90.17
90.18	09018	CHERRYVALLEY	0	0	0	0	0.000000	90.18
90.19	09019	KLECKNER	0	0	0	0	0.000000	90.19
90.20	09020	GALLERIA	0	0	0	0	0.000000	90.20
90.21	09021	RIVERSIDE MOB	0	0	0	0	0.000000	90.21
90.22	09022	MULFORD-LENOX	0	0	0	0	0.000000	90.22
91.00	09100	EMERGENCY	0	1,125,813	1,125,813	0	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	6,322	6,322	0	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)	0	1,898,840	1,898,840	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0239

Period:
From 07/01/2020
To 06/30/2021Worksheet D
Part IV
Date/Time Prepared:
4/27/2022 12:54 pm

				Title XIX		Hospital	Cost	
Cost Center Description			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.00
73.01	07301	INJECTABLE DRUGS	0.000000	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00	03340	GI LAB	0.000000	0	0	0	0	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09003	PAIN CENTER	0.000000	0	0	0	0	90.01
90.02	09001	ANTENATAL TEST CENTER	0.000000	0	0	0	0	90.02
90.03	09002	CHILD PSYCHIATRIC CLINIC	0.000000	0	0	0	0	90.03
90.04	09004	SPECIAL SURGICAL SERVICES	0.000000	0	0	0	0	90.04
90.05	09005	GENETIC SERVICES	0.000000	0	0	0	0	90.05
90.06	09006	HBP	0.000000	0	0	0	0	90.06
90.07	09007	MAIN	0.000000	0	0	0	0	90.07
90.08	09008	RMB	0.000000	0	0	0	0	90.08
90.09	09009	MULFORD	0.000000	0	0	0	0	90.09
90.10	09010	ALPINE	0.000000	0	0	0	0	90.10
90.11	09011	ROSCOE	0.000000	0	0	0	0	90.11
90.12	09012	BYRON	0.000000	0	0	0	0	90.12
90.13	09013	WINNEBAGO	0.000000	0	0	0	0	90.13
90.14	09014	PERRYVILLE	0.000000	0	0	0	0	90.14
90.15	09015	BELVIDERE	0.000000	0	0	0	0	90.15
90.16	09016	SPRINGBROOK	0.000000	0	0	0	0	90.16
90.17	09017	MCFARLAND	0.000000	0	0	0	0	90.17
90.18	09018	CHERRYVALLEY	0.000000	0	0	0	0	90.18
90.19	09019	KLECKNER	0.000000	0	0	0	0	90.19
90.20	09020	GALLERIA	0.000000	0	0	0	0	90.20
90.21	09021	RIVERSIDE MOB	0.000000	0	0	0	0	90.21
90.22	09022	MULFORD-LENOX	0.000000	0	0	0	0	90.22
91.00	09100	EMERGENCY	0.000000	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES						95.00
200.00		Total (lines 50 through 199)		0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0239

Period:

Worksheet D

Component CCN: 14-S239

From 07/01/2020
To 06/30/2021Part IV
Date/Time Prepared:
4/27/2022 12:54 pm

				Title XIX		Subprovider - IPF	Cost	
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	213,186
51.00	05100	RECOVERY ROOM	0	0	0	0	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	40,721
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	481,658
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	0
56.00	05600	RADIOISOTOPE	0	0	0	0	0	0
57.00	05700	CT SCAN	0	0	0	0	0	0
58.00	05800	MRI	0	0	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	0
60.00	06000	LABORATORY	0	0	0	0	0	0
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	0
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	31,140
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	0
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0
73.01	07301	INJECTABLE DRUGS	0	0	0	0	0	0
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	0
76.00	03340	GI LAB	0	0	0	0	0	0
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	0
76.99	07699	LITHOTRIPSY	0	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	0
90.01	09003	PAIN CENTER	0	0	0	0	0	0
90.02	09001	ANTENATAL TEST CENTER	0	0	0	0	0	0
90.03	09002	CHILD PSYCHIATRIC CLINIC	0	0	0	0	0	0
90.04	09004	SPECIAL SURGICAL SERVICES	0	0	0	0	0	0
90.05	09005	GENETIC SERVICES	0	0	0	0	0	0
90.06	09006	HBP	0	0	0	0	0	0
90.07	09007	MAIN	0	0	0	0	0	0
90.08	09008	RMB	0	0	0	0	0	0
90.09	09009	MULFORD	0	0	0	0	0	0
90.10	09010	ALPINE	0	0	0	0	0	0
90.11	09011	ROSCOE	0	0	0	0	0	0
90.12	09012	BYRON	0	0	0	0	0	0
90.13	09013	WINNEBAGO	0	0	0	0	0	0
90.14	09014	PERRYVILLE	0	0	0	0	0	0
90.15	09015	BELVIDERE	0	0	0	0	0	0
90.16	09016	SPRINGBROOK	0	0	0	0	0	0
90.17	09017	MCFARLAND	0	0	0	0	0	0
90.18	09018	CHERRYVALLEY	0	0	0	0	0	0
90.19	09019	KLECKNER	0	0	0	0	0	0
90.20	09020	GALLERIA	0	0	0	0	0	0
90.21	09021	RIVERSIDE MOB	0	0	0	0	0	0
90.22	09022	MULFORD-LENOX	0	0	0	0	0	0
91.00	09100	EMERGENCY	0	0	0	0	0	1,125,813
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES	0	0	0	0	0	0
200.00		Total (lines 50 through 199)	0	0	0	0	0	1,892,518

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0239 Component CCN: 14-S239		Period: From 07/01/2020 To 06/30/2021		Worksheet D Part IV Date/Time Prepared: 4/27/2022 12:54 pm	
				Title XIX		Subprovider - IPF		Cost	
Cost Center Description				All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
				4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0		213,186	213,186	0	0.000000	50.00
51.00	05100	RECOVERY ROOM	0		0	0	0	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		40,721	40,721	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		481,658	481,658	0	0.000000	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0		0	0	0	0.000000	55.00
56.00	05600	RADIOISOTOPE	0		0	0	0	0.000000	56.00
57.00	05700	CT SCAN	0		0	0	0	0.000000	57.00
58.00	05800	MRI	0		0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0		0	0	0	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	0.000000	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0		0	0	0	0.000000	63.00
64.00	06400	INTRAVENOUS THERAPY	0		0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0		31,140	31,140	0	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0		0	0	0	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0		0	0	0	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		0	0	0	0.000000	73.00
73.01	07301	INJECTABLE DRUGS	0		0	0	0	0.000000	73.01
74.00	07400	RENAL DIALYSIS	0		0	0	0	0.000000	74.00
76.00	03340	GI LAB	0		0	0	0	0.000000	76.00
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0		0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0		0	0	0	0.000000	90.00
90.01	09003	PAIN CENTER	0		0	0	0	0.000000	90.01
90.02	09001	ANTENATAL TEST CENTER	0		0	0	0	0.000000	90.02
90.03	09002	CHILD PSYCHIATRIC CLINIC	0		0	0	0	0.000000	90.03
90.04	09004	SPECIAL SURGICAL SERVICES	0		0	0	0	0.000000	90.04
90.05	09005	GENETIC SERVICES	0		0	0	0	0.000000	90.05
90.06	09006	HBP	0		0	0	0	0.000000	90.06
90.07	09007	MAIN	0		0	0	0	0.000000	90.07
90.08	09008	RMB	0		0	0	0	0.000000	90.08
90.09	09009	MULFORD	0		0	0	0	0.000000	90.09
90.10	09010	ALPINE	0		0	0	0	0.000000	90.10
90.11	09011	ROSCOE	0		0	0	0	0.000000	90.11
90.12	09012	BYRON	0		0	0	0	0.000000	90.12
90.13	09013	WINNEBAGO	0		0	0	0	0.000000	90.13
90.14	09014	PERRYVILLE	0		0	0	0	0.000000	90.14
90.15	09015	BELVIDERE	0		0	0	0	0.000000	90.15
90.16	09016	SPRINGBROOK	0		0	0	0	0.000000	90.16
90.17	09017	MCFARLAND	0		0	0	0	0.000000	90.17
90.18	09018	CHERRYVALLEY	0		0	0	0	0.000000	90.18
90.19	09019	KLECKNER	0		0	0	0	0.000000	90.19
90.20	09020	GALLERIA	0		0	0	0	0.000000	90.20
90.21	09021	RIVERSIDE MOB	0		0	0	0	0.000000	90.21
90.22	09022	MULFORD-LENOX	0		0	0	0	0.000000	90.22
91.00	09100	EMERGENCY	0		1,125,813	1,125,813	0	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0	0	0	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS									
95.00	09500	AMBULANCE SERVICES							95.00
200.00		Total (lines 50 through 199)	0		1,892,518	1,892,518	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0239

Period:

Worksheet D

Component CCN: 14-S239

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

Part IV
Date/Time Prepared:
4/27/2022 12:54 pm

				Title XIX		Subprovider - IPF	Cost	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)
				9.00	10.00	11.00	12.00	13.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM		0.000000	0	0	0	0 50.00
51.00	05100	RECOVERY ROOM		0.000000	0	0	0	0 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0.000000	0	0	0	0 52.00
53.00	05300	ANESTHESIOLOGY		0.000000	0	0	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.000000	0	0	0	0 54.00
55.00	05500	RADIOLOGY-THERAPEUTIC		0.000000	0	0	0	0 55.00
56.00	05600	RADIOISOTOPE		0.000000	0	0	0	0 56.00
57.00	05700	CT SCAN		0.000000	0	0	0	0 57.00
58.00	05800	MRI		0.000000	0	0	0	0 58.00
59.00	05900	CARDIAC CATHETERIZATION		0.000000	0	0	0	0 59.00
60.00	06000	LABORATORY		0.000000	0	0	0	0 60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS		0.000000	0	0	0	0 62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.		0.000000	0	0	0	0 63.00
64.00	06400	INTRAVENOUS THERAPY		0.000000	0	0	0	0 64.00
65.00	06500	RESPIRATORY THERAPY		0.000000	0	0	0	0 65.00
66.00	06600	PHYSICAL THERAPY		0.000000	0	0	0	0 66.00
69.00	06900	ELECTROCARDIOLOGY		0.000000	0	0	0	0 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0.000000	0	0	0	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.000000	0	0	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0.000000	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.000000	0	0	0	0 73.00
73.01	07301	INJECTABLE DRUGS		0.000000	0	0	0	0 73.01
74.00	07400	RENAL DIALYSIS		0.000000	0	0	0	0 74.00
76.00	03340	GI LAB		0.000000	0	0	0	0 76.00
76.97	07697	CARDIAC REHABILITATION		0.000000	0	0	0	0 76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		0.000000	0	0	0	0 76.98
76.99	07699	LITHOTRIPSY		0.000000	0	0	0	0 76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC		0.000000	0	0	0	0 90.00
90.01	09003	PAIN CENTER		0.000000	0	0	0	0 90.01
90.02	09001	ANTENATAL TEST CENTER		0.000000	0	0	0	0 90.02
90.03	09002	CHILD PSYCHIATRIC CLINIC		0.000000	0	0	0	0 90.03
90.04	09004	SPECIAL SURGICAL SERVICES		0.000000	0	0	0	0 90.04
90.05	09005	GENETIC SERVICES		0.000000	0	0	0	0 90.05
90.06	09006	HBP		0.000000	0	0	0	0 90.06
90.07	09007	MAIN		0.000000	0	0	0	0 90.07
90.08	09008	RMB		0.000000	0	0	0	0 90.08
90.09	09009	MULFORD		0.000000	0	0	0	0 90.09
90.10	09010	ALPINE		0.000000	0	0	0	0 90.10
90.11	09011	ROSCOE		0.000000	0	0	0	0 90.11
90.12	09012	BYRON		0.000000	0	0	0	0 90.12
90.13	09013	WINNEBAGO		0.000000	0	0	0	0 90.13
90.14	09014	PERRYVILLE		0.000000	0	0	0	0 90.14
90.15	09015	BELVIDERE		0.000000	0	0	0	0 90.15
90.16	09016	SPRINGBROOK		0.000000	0	0	0	0 90.16
90.17	09017	MCFARLAND		0.000000	0	0	0	0 90.17
90.18	09018	CHERRYVALLEY		0.000000	0	0	0	0 90.18
90.19	09019	KLECKNER		0.000000	0	0	0	0 90.19
90.20	09020	GALLERIA		0.000000	0	0	0	0 90.20
90.21	09021	RIVERSIDE MOB		0.000000	0	0	0	0 90.21
90.22	09022	MULFORD-LENOX		0.000000	0	0	0	0 90.22
91.00	09100	EMERGENCY		0.000000	0	0	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0.000000	0	0	0	0 92.00
OTHER REIMBURSABLE COST CENTERS								
95.00	09500	AMBULANCE SERVICES			0	0	0	0 95.00
200.00		Total (lines 50 through 199)			0	0	0	0 200.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0239

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

Worksheet D-1

Date/Time Prepared:
4/27/2022 12:54 pm

Title XVIII		Hospital	PPS
Cost Center Description			1.00
PART I - ALL PROVIDER COMPONENTS			
INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	37,334	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	37,334	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)	31,539	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)	10,372	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)	35,640,207	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)	35,640,207	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)	35,640,207	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)	954.63	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	9,901,422	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)	9,901,422	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0239

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

Worksheet D-1

Date/Time Prepared:
4/27/2022 12:54 pm

Cost Center Description		Title XVIII		Hospital		PPS	
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	9,249,488	5,333	1,734.39	1,663	2,884,291	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
46.01	NEONATAL INTENSIVE CARE	11,481,522	9,653	1,189.43	0	0	46.01
46.02	PEDIATRIC INTENSIVE CARE	53,053	0	0.00	0	0	46.02
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (wkst. D-3, col. 3, line 200)					22,124,383	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					34,910,096	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)					1,290,678	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					3,162,862	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					4,453,540	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					30,456,556	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)					5,795	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					954.63	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					5,532,081	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0239

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

Worksheet D-1

Date/Time Prepared:
4/27/2022 12:54 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	3,421,990	35,640,207	0.096015	5,532,081	531,163
91.00	Nursing Program cost	0	35,640,207	0.000000	5,532,081	0
92.00	Allied health cost	40,721	35,640,207	0.001143	5,532,081	6,323
93.00	All other Medical Education	0	35,640,207	0.000000	5,532,081	0

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0239

Period:

Worksheet D-1

Component CCN: 14-S239

From 07/01/2020
To 06/30/2021Date/Time Prepared:
4/27/2022 12:54 pm

Title XVIII

Subprovider -
IPF

PPS

Cost Center Description		1.00	
PART I - ALL PROVIDER COMPONENTS			
INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	74	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	74	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)	74	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	13	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)	519,872	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)	519,872	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)	519,872	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)	7,025.30	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	91,329	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)	91,329	41.00

Health Financial Systems		JAVON BEA HOSPITAL		In Lieu of Form CMS-2552-10	
COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0239	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1
			Component CCN: 14-S239	Date/Time Prepared: 4/27/2022 12:54 pm	
			Title XVIII	Subprovider - IPF	PPS
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0
Intensive Care Type Inpatient Hospital Units					
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0
44.00 CORONARY CARE UNIT					
45.00 BURN INTENSIVE CARE UNIT					
46.00 SURGICAL INTENSIVE CARE UNIT					
46.01 NEONATAL INTENSIVE CARE	0	0	0.00	0	0
46.02 PEDIATRIC INTENSIVE CARE	0	0	0.00	0	0
47.00 OTHER SPECIAL CARE (SPECIFY)					
Cost Center Description					1.00
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					6,103
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					97,432
PASS THROUGH COST ADJUSTMENTS					
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					20,963
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					918
52.00 Total Program excludable cost (sum of lines 50 and 51)					21,881
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					75,551
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00 Program discharges					0
55.00 Target amount per discharge					0.00
56.00 Target amount (line 54 x line 55)					0
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00 Bonus payment (see instructions)					0
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0
62.00 Relief payment (see instructions)					0
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0
PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY					
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					
72.00 Program routine service cost (line 9 x line 71)					
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)					
74.00 Total Program general inpatient routine service costs (line 72 + line 73)					
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					
76.00 Per diem capital-related costs (line 75 ÷ line 2)					
77.00 Program capital-related costs (line 9 x line 76)					
78.00 Inpatient routine service cost (line 74 minus line 77)					
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)					
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					
81.00 Inpatient routine service cost per diem limitation					
82.00 Inpatient routine service cost limitation (line 9 x line 81)					
83.00 Reasonable inpatient routine service costs (see instructions)					
84.00 Program inpatient ancillary services (see instructions)					
85.00 Utilization review - physician compensation (see instructions)					
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)					
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00 Total observation bed days (see instructions)					0
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0239

Period:

Worksheet D-1

Component CCN: 14-S239

From 07/01/2020
To 06/30/2021Date/Time Prepared:
4/27/2022 12:54 pm

Title XVIII

Subprovider -
IPF

PPS

Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	119,326	519,872	0.229530	0	0	90.00
91.00 Nursing Program cost	0	519,872	0.000000	0	0	91.00
92.00 Allied health cost	0	519,872	0.000000	0	0	92.00
93.00 All other Medical Education	0	519,872	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0239

Period:

Worksheet D-1

Component CCN: 14-6196

From 07/01/2020
To 06/30/2021Date/Time Prepared:
4/27/2022 12:54 pm

Title XVIII

Skilled Nursing
Facility

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)	0	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	0	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)	0	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)	0	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)	262,519	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)	262,519	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)	262,519	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)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

Health Financial Systems		JAVON BEA HOSPITAL			In Lieu of Form CMS-2552-10		
COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0239 Component CCN: 14-6196		Period: From 07/01/2020 To 06/30/2021 Worksheet D-1 Date/Time Prepared: 4/27/2022 12:54 pm	
				Title XVIII		Skilled Nursing Facility 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)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
46.01	NEONATAL INTENSIVE CARE						46.01
46.02	PEDIATRIC INTENSIVE CARE						46.02
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
							1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						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)						50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)						52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges						54.00
55.00	Target amount per discharge						55.00
56.00	Target amount (line 54 x line 55)						56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57.00
58.00	Bonus payment (see instructions)						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						59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						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)						61.00
62.00	Relief payment (see instructions)						62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)						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)						64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						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)						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)						68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						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)						262,519 70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						0.00 71.00
72.00	Program routine service cost (line 9 x line 71)						0 72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						0 73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						0 74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						0 75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						0.00 76.00
77.00	Program capital-related costs (line 9 x line 76)						0 77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						0 78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						0 79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						0 80.00
81.00	Inpatient routine service cost per diem limitation						0.00 81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						0 82.00
83.00	Reasonable inpatient routine service costs (see instructions)						0 83.00
84.00	Program inpatient ancillary services (see instructions)						0 84.00
85.00	Utilization review - physician compensation (see instructions)						0 85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						0 86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)						0 87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						0.00 88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)						0 89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0239

Period:

Worksheet D-1

Component CCN: 14-6196

From 07/01/2020
To 06/30/2021Date/Time Prepared:
4/27/2022 12:54 pm

Title XVIII

Skilled Nursing
Facility

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	0	0	0.000000	0	0	90.00
91.00	Nursing Program cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0239

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

Worksheet D-1

Date/Time Prepared:
4/27/2022 12:54 pm

Title XIX		Hospital	Cost
Cost Center Description			1.00
PART I - ALL PROVIDER COMPONENTS			
INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	37,334	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	37,334	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)	31,539	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	2,562	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)	1,530	15.00
16.00	Nursery days (title V or XIX only)	458	16.00
SWING BED ADJUSTMENT			
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	46,332,542	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	46,332,542	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	46,332,542	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY			
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS			
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,241.03	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	3,179,519	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)	3,179,519	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0239

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

Worksheet D-1

Date/Time Prepared:
4/27/2022 12:54 pm

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)	4,289,051	1,530	2,803.30	458	1,283,911	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	9,249,488	5,333	1,734.39	438	759,663	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
46.01	NEONATAL INTENSIVE CARE	11,481,522	9,653	1,189.43	2,258	2,685,733	46.01
46.02	PEDIATRIC INTENSIVE CARE	53,053	0	0.00	0	0	46.02
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
							1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					7,908,826	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					5,795	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,241.03	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					7,191,769	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0239

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

Worksheet D-1

Date/Time Prepared:
4/27/2022 12:54 pm

		Title XIX		Hospital		Cost	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	3,421,990	46,332,542	0.073857	7,191,769	531,162	90.00
91.00	Nursing Program cost	0	46,332,542	0.000000	7,191,769	0	91.00
92.00	Allied health cost	40,721	46,332,542	0.000879	7,191,769	6,322	92.00
93.00	All other Medical Education	0	46,332,542	0.000000	7,191,769	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0239 Component CCN: 14-S239	Period: From 07/01/2020 To 06/30/2021	Worksheet D-1 Date/Time Prepared: 4/27/2022 12:54 pm
		Title XIX	Subprovider - IPF	Cost
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			74 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			74 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)			74 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)			11 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)			1,530 15.00
16.00	Nursery days (title V or XIX only)			458 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)			519,872 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)			519,872 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)			519,872 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)			7,025.30 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			77,278 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)			77,278 41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0239

Period:

Worksheet D-1

Component CCN: 14-S239

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

Date/Time Prepared:

4/27/2022 12:54 pm

		Title XIX		Subprovider - IPF		Cost	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
46.01	NEONATAL INTENSIVE CARE	0	0	0.00	0	0	46.01
46.02	PEDIATRIC INTENSIVE CARE	0	0	0.00	0	0	46.02
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
							1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					77,278	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0239

Period:

Worksheet D-1

Component CCN: 14-S239

From 07/01/2020

Date/Time Prepared:

To 06/30/2021

4/27/2022 12:54 pm

Title XIX

Subprovider -
IPF

Cost

Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	119,326	519,872	0.229530	0	0	90.00
91.00 Nursing Program cost	0	519,872	0.000000	0	0	91.00
92.00 Allied health cost	0	519,872	0.000000	0	0	92.00
93.00 All other Medical Education	0	519,872	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0239	Period: From 07/01/2020 To 06/30/2021	Worksheet D-3 Date/Time Prepared: 4/27/2022 12:54 pm
Cost Center Description			Title XVIII	Hospital	PPS
			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
			1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		18,732,511	30.00
31.00	03100	INTENSIVE CARE UNIT		8,262,651	31.00
34.01	03401	NEONATAL INTENSIVE CARE		0	34.01
34.02	03402	PEDIATRIC INTENSIVE CARE		0	34.02
40.00	04000	SUBPROVIDER - IPF		2,029	40.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.367038	8,636,913	50.00
51.00	05100	RECOVERY ROOM	0.260538	833,644	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.351356	44,921	52.00
53.00	05300	ANESTHESIOLOGY	0.092149	1,486,876	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.142086	13,483,476	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.178252	39,738	55.00
56.00	05600	RADIOISOTOPE	0.109700	809,371	56.00
57.00	05700	CT SCAN	0.038151	10,217,156	57.00
58.00	05800	MRI	0.081140	2,285,874	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.127961	18,481,263	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	63.00
64.00	06400	INTRAVENOUS THERAPY	0.026121	159,395	64.00
65.00	06500	RESPIRATORY THERAPY	0.165961	6,663,155	65.00
66.00	06600	PHYSICAL THERAPY	0.244232	3,062,293	66.00
69.00	06900	ELECTROCARDIOLOGY	0.079449	4,825,936	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.179251	397,350	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.154888	22,138,645	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.170809	10,936,150	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.146891	22,600,326	73.00
73.01	07301	INJECTABLE DRUGS	0.000000	0	73.01
74.00	07400	RENAL DIALYSIS	0.634556	755,277	74.00
76.00	03340	GI LAB	0.285671	599,477	76.00
76.97	07697	CARDIAC REHABILITATION	0.000000	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.000000	0	90.00
90.01	09003	PAIN CENTER	0.152743	8,706	90.01
90.02	09001	ANTENATAL TEST CENTER	0.140857	9,469	90.02
90.03	09002	CHILD PSYCHIATRIC CLINIC	0.788480	0	90.03
90.04	09004	SPECIAL SURGICAL SERVICES	0.353363	9,843	90.04
90.05	09005	GENETIC SERVICES	2.272573	0	90.05
90.06	09006	HBP	0.728197	2,413	90.06
90.07	09007	MAIN	0.577992	11,139	90.07
90.08	09008	RMB	0.425739	711	90.08
90.09	09009	MULFORD	2.190026	1,629	90.09
90.10	09010	ALPINE	1.185789	1,381	90.10
90.11	09011	ROSCOE	1.549950	2,171	90.11
90.12	09012	BYRON	2.297477	516	90.12
90.13	09013	WINNEBAGO	1.144241	1,417	90.13
90.14	09014	PERRYVILLE	0.347416	10,580	90.14
90.15	09015	BELVIDERE	0.623591	308	90.15
90.16	09016	SPRINGBROOK	0.340797	223	90.16
90.17	09017	MCFARLAND	0.525672	0	90.17
90.18	09018	CHERRYVALLEY	1.219611	827	90.18
90.19	09019	KLECKNER	0.000000	0	90.19
90.20	09020	GALLERIA	0.489070	0	90.20
90.21	09021	RIVERSIDE MOB	0.656929	2,697	90.21
90.22	09022	MULFORD-LENOX	0.585023	0	90.22
91.00	09100	EMERGENCY	0.245665	6,473,313	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.436055	985,257	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500	AMBULANCE SERVICES			95.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		135,979,836	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net charges (line 200 minus line 201)		135,979,836	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0239 Component CCN: 14-S239	Period: From 07/01/2020 To 06/30/2021	Worksheet D-3 Date/Time Prepared: 4/27/2022 12:54 pm	
		Title XVIII	Subprovider - IPF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS				30.00
31.00	03100 INTENSIVE CARE UNIT				31.00
34.01	03401 NEONATAL INTENSIVE CARE				34.01
34.02	03402 PEDIATRIC INTENSIVE CARE				34.02
40.00	04000 SUBPROVIDER - IPF		20,768		40.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.367038	0	0	50.00
51.00	05100 RECOVERY ROOM	0.260538	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.351356	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.092149	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.142086	2,937	417	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.178252	0	0	55.00
56.00	05600 RADIOISOTOPE	0.109700	0	0	56.00
57.00	05700 CT SCAN	0.038151	3,292	126	57.00
58.00	05800 MRI	0.081140	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000 LABORATORY	0.127961	6,133	785	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	63.00
64.00	06400 INTRAVENOUS THERAPY	0.026121	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.165961	9,675	1,606	65.00
66.00	06600 PHYSICAL THERAPY	0.244232	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0.079449	721	57	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.179251	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.154888	992	154	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.170809	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.146891	9,254	1,359	73.00
73.01	07301 INJECTABLE DRUGS	0.000000	0	0	73.01
74.00	07400 RENAL DIALYSIS	0.634556	0	0	74.00
76.00	03340 GI LAB	0.285671	0	0	76.00
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699 LITHOTRIPSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.000000	0	0	90.00
90.01	09003 PAIN CENTER	0.152743	0	0	90.01
90.02	09001 ANTENATAL TEST CENTER	0.140857	0	0	90.02
90.03	09002 CHILD PSYCHIATRIC CLINIC	0.788480	0	0	90.03
90.04	09004 SPECIAL SURGICAL SERVICES	0.353363	0	0	90.04
90.05	09005 GENETIC SERVICES	2.272573	0	0	90.05
90.06	09006 HBP	0.728197	0	0	90.06
90.07	09007 MAIN	0.577992	0	0	90.07
90.08	09008 RMB	0.425739	0	0	90.08
90.09	09009 MULFORD	2.190026	0	0	90.09
90.10	09010 ALPINE	1.185789	0	0	90.10
90.11	09011 ROSCOE	1.549950	0	0	90.11
90.12	09012 BYRON	2.297477	0	0	90.12
90.13	09013 WINNEBAGO	1.144241	0	0	90.13
90.14	09014 PERRYVILLE	0.347416	0	0	90.14
90.15	09015 BELVIDERE	0.623591	0	0	90.15
90.16	09016 SPRINGBROOK	0.340797	0	0	90.16
90.17	09017 MCFARLAND	0.525672	0	0	90.17
90.18	09018 CHERRYVALLEY	1.219611	0	0	90.18
90.19	09019 KLECKNER	0.000000	0	0	90.19
90.20	09020 GALLERIA	0.489070	0	0	90.20
90.21	09021 RIVERSIDE MOB	0.656929	0	0	90.21
90.22	09022 MULFORD-LENOX	0.585023	0	0	90.22
91.00	09100 EMERGENCY	0.245665	6,507	1,599	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.436055	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95.00	09500 AMBULANCE SERVICES				95.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		39,511	6,103	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)		39,511		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0239

Period:
From 07/01/2020
To 06/30/2021Worksheet E
Part A
Date/Time Prepared:
4/27/2022 12:54 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)			7,591,869	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)			19,142,799	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)			171,045	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)			434,304	2.04
3.00	Managed Care Simulated Payments			18,290,475	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)			231.61	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.			0.31	14.00
15.00	Sum of lines 12 through 14 divided by 3.			0.10	15.00
16.00	Adjustment for residents in initial years of the program			48.97	16.00
17.00	Adjustment for residents displaced by program or hospital closure			0.00	17.00
18.00	Adjusted rolling average FTE count			49.07	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).			0.211865	19.00
20.00	Prior year resident to bed ratio (see instructions)			0.173505	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)			0.173505	21.00
22.00	IME payment adjustment (see instructions)			2,416,092	22.00
22.01	IME payment adjustment - Managed Care (see instructions)			1,652,965	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)			2,416,092	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			1,652,965	29.01
Disproportionate Share Adjustment					
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)			5.14	30.00
31.00	Percentage of Medicaid patient days (see instructions)			27.80	31.00
32.00	Sum of lines 30 and 31			32.94	32.00
33.00	Allowable disproportionate share percentage (see instructions)			16.39	33.00
34.00	Disproportionate share adjustment (see instructions)			1,095,453	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0239

Period:
From 07/01/2020
To 06/30/2021Worksheet E
Part A
Date/Time Prepared:
4/27/2022 12:54 pm

		Title XVIII	Hospital	PPS	
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
	Uncompensated Care Adjustment				
35.00	Total uncompensated care amount (see instructions)		0	0	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000		35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	1,164,955	1,348,723		35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	292,830	1,008,771		35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,301,601			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)	32,153,163			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)		33,806,128		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		2,524,484		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).		1,696,662		52.00
53.00	Nursing and Allied Health Managed Care payment		91,021		53.00
54.00	Special add-on payments for new technologies		131,540		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 intructions)		0		56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		11,305		57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		238,226		58.00
59.00	Total (sum of amounts on lines 49 through 58)		38,499,366		59.00
60.00	Primary payer payments		19,085		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		38,480,281		61.00
62.00	Deductibles billed to program beneficiaries		2,567,612		62.00
63.00	Coinsurance billed to program beneficiaries		35,979		63.00
64.00	Allowable bad debts (see instructions)		940,417		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		611,271		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		645,406		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		36,487,961		67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0		68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)		0		69.00
70.00	MEDI/MEDI BAD DEBT RETROACTIVE ADJ		0		70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)		0		70.50
70.87	Demonstration payment adjustment amount before sequestration		0		70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0		70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0		70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0		70.91
70.92	Bundled Model 1 discount amount (see instructions)		0		70.92
70.93	HVBP payment adjustment amount (see instructions)		-101,436		70.93
70.94	HRR adjustment amount (see instructions)		-145,781		70.94
70.95	Recovery of accelerated depreciation		0		70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0239

Period:
From 07/01/2020
To 06/30/2021Worksheet E
Part A
Date/Time Prepared:
4/27/2022 12:54 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)			362,149	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)			35,878,595	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			31,434,601	72.00
72.01	Interim payments-PARHM				72.01
73.00	Tentative settlement (for contractor use only)			0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)				73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)			4,443,994	74.00
74.01	Balance due provider/program-PARHM (see instructions)				74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			921,106	75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)			0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2			0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)			0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)			0	93.00
94.00	The rate used to calculate the time value of money (see instructions)			0.00	94.00
95.00	Time value of money for operating expenses (see instructions)			0	95.00
96.00	Time value of money for capital related expenses (see instructions)			0	96.00
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)		0	0	100.00
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)		0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	0	102.00
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)		0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	0	104.00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)				201.00
202.00	Medicare discharges (see instructions)				202.00
203.00	Case-mix adjustment factor (see instructions)				203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
204.00	Medicare target amount				204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)				205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)				206.00
Adjustment to Medicare Part A Inpatient Reimbursement					
207.00	Program reimbursement under the §410A Demonstration (see instructions)				207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)				208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)				211.00
Comparison of PPS versus Cost Reimbursement					
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)				212.00
213.00	Low-volume adjustment (see instructions)				213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)				218.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0239

Period:
From 07/01/2020
To 06/30/2021Worksheet E
Part A Exhibit 5
Date/Time Prepared:
4/27/2022 12:54 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	7,591,869	7,591,869		7,591,869	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	19,142,799		19,142,799	19,142,799	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	171,045	171,045		171,045	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	434,304		434,304	434,304	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	18,290,475	4,338,635	13,951,840	18,290,475	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.173505	0.173505	0.173505		5.00
6.00	IME payment adjustment (see instructions)	22.00	2,416,092	686,100	1,729,992	2,416,092	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	1,652,965	392,095	1,260,870	1,652,965	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	2,416,092	686,100	1,729,992	2,416,092	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	1,652,965	392,095	1,260,870	1,652,965	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1639	0.1639	0.1639		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	1,095,453	311,077	784,376	1,095,453	11.00
11.01	Uncompensated care payments	36.00	1,301,601	292,830	1,008,771	1,301,601	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	32,153,163	9,052,921	23,100,242	32,153,163	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	33,806,128	9,445,016	24,361,112	33,806,128	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	2,524,484	734,476	1,790,008	2,524,484	16.00
17.00	Special add-on payments for new technologies	54.00	131,540	33,155	98,385	131,540	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			10,212,647	26,249,505	36,462,152	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0239

Period:
From 07/01/2020
To 06/30/2021Worksheet E
Part A Exhibit 5
Date/Time Prepared:
4/27/2022 12:54 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	2,055,915	600,613	1,455,302	2,055,915	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	97,476	25,453	72,023	97,476	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	0.1115	0.1115	0.1115		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	229,235	66,968	162,267	229,235	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0690	0.0690	0.0690		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	141,858	41,442	100,416	141,858	25.00
26.00	Total prospective capital payments (see instructions)	12.00	2,524,484	734,476	1,790,008	2,524,484	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	-101,436	-43,628	-57,808	-101,436	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	-145,781	-20,497	-125,284	-145,781	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		101,485	260,664	362,149	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0239	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part B Date/Time Prepared: 4/27/2022 12:54 pm
		Title XVIII	Hospital	PPS
			1.00	
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		79,196	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		22,548,060	2.00
3.00	OPPS payments		20,454,175	3.00
4.00	Outlier payment (see instructions)		105,668	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		180,838	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		79,196	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		539,150	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)		539,150	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)		539,150	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		459,954	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)		79,196	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		20,740,681	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		3,519,042	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)		17,300,835	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		1,105,288	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)		18,406,123	30.00
31.00	Primary payer payments		14,961	31.00
32.00	Subtotal (line 30 minus line 31)		18,391,162	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)		693,049	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		450,482	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		500,387	36.00
37.00	Subtotal (see instructions)		18,841,644	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	FORMULA DRIVEN OVERPAYMENT EST		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)		18,841,644	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		18,246,349	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)		595,295	43.00
43.01	Balance due provider/program-PARHM (see instructions)		0	43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN:14-0239 Component CCN:14-S239	Period: From 07/01/2020 To 06/30/2021	Worksheet E Part B Date/Time Prepared: 4/27/2022 12:54 pm
		Title XVIII	Subprovider - IPF	PPS
			1.00	
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		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 chargebasis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		0	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		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: 14-0239

Period:
From 07/01/2020
To 06/30/2021Worksheet E-1
Part I
Date/Time Prepared:
4/27/2022 12:54 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		30,601,401		17,727,949	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	06/30/2021	833,200	06/30/2021	518,400	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)		833,200		518,400	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)		31,434,601		18,246,349	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		4,443,994		595,295	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		35,878,595		18,841,644	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN:14-0239

Period:

Worksheet E-1

Component CCN:14-S239

From 07/01/2020

Part I

To 06/30/2021

Date/Time Prepared:

4/27/2022 12:54 pm

Title XVIII

Subprovider -
IPF

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		8,666		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)		8,666		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		9,924		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		18,590		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 14-0239

Period:
From 07/01/2020
To 06/30/2021Worksheet E-1
Part II
Date/Time Prepared:
4/27/2022 12:54 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 (Wkst. S-3, Pt. I, col. 6, sum of lines 1, and 8 through 12, and plus for cost reporting periods beginning on or after 10/01/2013, line 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 (Wkst. S-3, Pt. I, col. 8, sum of lines 1, and 8 through 12, and plus for cost reporting periods beginning on or after 10/01/2013, line 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: 14-0239

Period:

Worksheet E-3

Component CCN: 14-S239

From 07/01/2020
To 06/30/2021Part II
Date/Time Prepared:
4/27/2022 12:54 pm

Title XVIII

Subprovider -
IPF

PPS

1.00

PART II - MEDICARE PART A SERVICES - IPF PPS

1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	11,482	1.00
2.00	Net IPF PPS Outlier Payments	0	2.00
3.00	Net IPF PPS ECT Payments	0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)	0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	4.01
5.00	New Teaching program adjustment. (see instructions)	0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)	0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)	0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.00	8.00
9.00	Average Daily Census (see instructions)	0.020740	9.00
10.00	Teaching Adjustment Factor $\{(1 + (\text{line 8/line 9})) \text{ raised to the power of } .5150 - 1\}$.	0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).	0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	11,482	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)	0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)	0	14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)	0	15.00
16.00	Subtotal (see instructions)	11,482	16.00
17.00	Primary payer payments	0	17.00
18.00	Subtotal (line 16 less line 17).	11,482	18.00
19.00	Deductibles	2,816	19.00
20.00	Subtotal (line 18 minus line 19)	8,666	20.00
21.00	Coinsurance	0	21.00
22.00	Subtotal (line 20 minus line 21)	8,666	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	15,025	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	9,766	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	25.00
26.00	Subtotal (sum of lines 22 and 24)	18,432	26.00
27.00	Direct graduate medical education payments (see instructions)	0	27.00
28.00	Other pass through costs (see instructions)	158	28.00
29.00	Outlier payments reconciliation	0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	30.50
30.98	Recovery of accelerated depreciation.	0	30.98
30.99	Demonstration payment adjustment amount before sequestration	0	30.99
31.00	Total amount payable to the provider (see instructions)	18,590	31.00
31.01	Sequestration adjustment (see instructions)	0	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	31.02
32.00	Interim payments	8,666	32.00
33.00	Tentative settlement (for contractor use only)	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)	9,924	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	35.00
TO BE COMPLETED BY CONTRACTOR			
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	0	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00
FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING BEFORE THE END OF THE COVID-19 PHE			
99.00	Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.	0.000000	99.00
99.01	Calculated Teaching Adjustment Factor for the current year. (see instructions)	0.000000	99.01

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0239 Component CCN: 14-6196	Period: From 07/01/2020 To 06/30/2021	Worksheet E-3 Part VI Date/Time Prepared: 4/27/2022 12:54 pm
		Title XVIII	Skilled Nursing Facility	PPS
				1.00
PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES				
PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)				
1.00	Resource Utilization Group Payment (RUGS)		0	1.00
2.00	Routine service other pass through costs		0	2.00
3.00	Ancillary service other pass through costs		0	3.00
4.00	Subtotal (sum of lines 1 through 3)		0	4.00
COMPUTATION OF NET COST OF COVERED SERVICES				
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)			5.00
6.00	Deductible		0	6.00
7.00	Coinsurance		0	7.00
8.00	Allowable bad debts (see instructions)		0	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)		0	10.00
11.00	Utilization review		0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)		0	12.00
13.00	Inpatient primary payer payments		0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	14.50
14.98	Recovery of accelerated depreciation.		0	14.98
14.99	Demonstration payment adjustment amount before sequestration		0	14.99
15.00	Subtotal (see instructions)		0	15.00
15.01	Sequestration adjustment (see instructions)		0	15.01
15.02	Demonstration payment adjustment amount after sequestration		0	15.02
15.75	Sequestration for non-claims based amounts (see instructions)		0	15.75
16.00	Interim payments		0	16.00
17.00	Tentative settlement (for contractor use only)		0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 15.02, 15.75, 16, and 17)		0	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2		0	19.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0239

Period:
From 07/01/2020
To 06/30/2021Worksheet E-3
Part VII
Date/Time Prepared:
4/27/2022 12:54 pm

		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		7,908,826		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		7,908,826	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		7,908,826	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		0		8.00
9.00	Ancillary service charges		0	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		0	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		7,908,826	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		0	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		0	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		7,908,826	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	0	31.00
32.00	Deductibles		0	0	32.00
33.00	Coinurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40.00
41.00	Interim payments		0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0239 Component CCN: 14-S239	Period: From 07/01/2020 To 06/30/2021	Worksheet E-3 Part VII Date/Time Prepared: 4/27/2022 12:54 pm	
		Title XIX	Subprovider - IPF	Cost	
			Inpatient 1.00	Outpatient 2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		77,278		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		77,278	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		77,278	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		0		8.00
9.00	Ancillary service charges		0	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		0	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		77,278	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		0	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0	0	24.00
25.00	Capital exception payments (see instructions)		0	0	25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		0	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		77,278	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	0	31.00
32.00	Deductibles		0	0	32.00
33.00	Coinsurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40.00
41.00	Interim payments		0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0239		Period: From 07/01/2020 To 06/30/2021		Worksheet E-4 Date/Time Prepared: 4/27/2022 12:54 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)					48.97	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.	48.97	0.00	48.97		8.00	
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	0.00	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)	0.31	0.00			13.00	
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	0.10	0.00			14.00	
15.00	Adjustment for residents in initial years of new programs	48.97	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	49.07	0.00			17.00	
18.00	Per resident amount	131,592.48	125,068.52			18.00	
19.00	Approved amount for resident costs	6,457,243	0	6,457,243		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)			48.97		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)			6,457,243		25.00	
		Inpatient Part A	Managed Care Prior to 1/1	Managed Care On or after 1/1	Total		
		1.00	2.00	2.01	3.00		
COMPUTATION OF PROGRAM PATIENT LOAD							
26.00	Inpatient Days (see instructions) (Title XIX - see S-2 Part IX, line 3.02, column 2)	12,048	4,548	4,547			26.00
27.00	Total Inpatient Days (see instructions)	47,872	47,872	47,872			27.00
28.00	Ratio of inpatient days to total inpatient days	0.251671	0.095003	0.094982			28.00
29.00	Program direct GME amount	1,625,101	613,457	613,322	2,851,880	29.00	
29.01	Percent reduction for MA DGME		4.07	4.07			29.01
30.00	Reduction for direct GME payments for Medicare Advantage		24,968	24,962	49,930	30.00	
31.00	Net Program direct GME amount				2,801,950	31.00	

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0239	Period: From 07/01/2020 To 06/30/2021	Worksheet E-4 Date/Time Prepared: 4/27/2022 12:54 pm
		Title XVIII	Hospital	PPS
			1.00	
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING PROGRAM AND PARAMEDICAL EDUCATION COSTS)				
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)		0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)		1,491,286	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)		35,007,528	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)		19,085	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)		34,988,443	41.00
Part B Reasonable Cost				
42.00	Reasonable cost (see instructions)		22,808,094	42.00
43.00	Primary payer payments (see instructions)		14,961	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)		22,793,133	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)		57,781,576	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)		0.605529	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)		0.394471	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48.00	Total program GME payment (line 31)		2,801,950	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)		1,696,662	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)		1,105,288	50.00

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

Provider CCN: 14-0239

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

Worksheet G

Date/Time Prepared:
4/27/2022 12:54 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	44,963,695	0	0	0	1.00
2.00 Temporary investments	0	0	0	0	2.00
3.00 Notes receivable	0	0	0	0	3.00
4.00 Accounts receivable	18,644,225	0	0	0	4.00
5.00 Other receivable	13,001,708	0	0	0	5.00
6.00 Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00 Inventory	11,580,220	0	0	0	7.00
8.00 Prepaid expenses	1,864,547	0	0	0	8.00
9.00 Other current assets	0	0	0	0	9.00
10.00 Due from other funds	1,126,135	0	0	0	10.00
11.00 Total current assets (sum of lines 1-10)	91,180,530	0	0	0	11.00
FIXED ASSETS					
12.00 Land	8,168,764	0	0	0	12.00
13.00 Land improvements	12,959,720	0	0	0	13.00
14.00 Accumulated depreciation	-8,037,514	0	0	0	14.00
15.00 Buildings	402,186,173	0	0	0	15.00
16.00 Accumulated depreciation	-66,084,975	0	0	0	16.00
17.00 Leasehold improvements	965,313	0	0	0	17.00
18.00 Accumulated depreciation	-807,006	0	0	0	18.00
19.00 Fixed equipment	178,609,737	0	0	0	19.00
20.00 Accumulated depreciation	-121,774,398	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	252,516,292	0	0	0	23.00
24.00 Accumulated depreciation	-184,213,858	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)	474,488,248	0	0	0	30.00
OTHER ASSETS					
31.00 Investments	172,459,455	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	21,812,433	0	0	0	34.00
35.00 Total other assets (sum of lines 31-34)	194,271,888	0	0	0	35.00
36.00 Total assets (sum of lines 11, 30, and 35)	759,940,666	0	0	0	36.00
CURRENT LIABILITIES					
37.00 Accounts payable	21,877,024	0	0	0	37.00
38.00 Salaries, wages, and fees payable	25,439,072	0	0	0	38.00
39.00 Payroll taxes payable	0	0	0	0	39.00
40.00 Notes and loans payable (short term)	0	0	0	0	40.00
41.00 Deferred income	655,440	0	0	0	41.00
42.00 Accelerated payments	0	0	0	0	42.00
43.00 Due to other funds	0	0	0	0	43.00
44.00 Other current liabilities	18,590,163	0	0	0	44.00
45.00 Total current liabilities (sum of lines 37 thru 44)	66,561,699	0	0	0	45.00
LONG TERM LIABILITIES					
46.00 Mortgage payable	0	0	0	0	46.00
47.00 Notes payable	458,730,833	0	0	0	47.00
48.00 Unsecured loans	0	0	0	0	48.00
49.00 Other long term liabilities	83,625,707	0	0	0	49.00
50.00 Total long term liabilities (sum of lines 46 thru 49)	542,356,540	0	0	0	50.00
51.00 Total liabilities (sum of lines 45 and 50)	608,918,239	0	0	0	51.00
CAPITAL ACCOUNTS					
52.00 General fund balance	151,022,427	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)	151,022,427	0	0	0	59.00
60.00 Total liabilities and fund balances (sum of lines 51 and 59)	759,940,666	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0239

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

Worksheet G-1

Date/Time Prepared:
4/27/2022 12:54 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		133,226,928		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		69,989,818				2.00
3.00	Total (sum of line 1 and line 2)		203,216,746		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00	FAS 133 VALUATION CHANGE	0		0		0	5.00
6.00	RESTRICTED ASSETS CHANGE	0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		203,216,746		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00	TRANSFERS	52,194,319		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00	OTHER	0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		52,194,319		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		151,022,427		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00	FAS 133 VALUATION CHANGE		0				5.00
6.00	RESTRICTED ASSETS CHANGE		0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00	TRANSFERS		0				13.00
14.00			0				14.00
15.00			0				15.00
16.00	OTHER		0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-0239

Period:
From 07/01/2020
To 06/30/2021Worksheet G-2
Parts I & II
Date/Time Prepared:
4/27/2022 12:54 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	63,238,360		63,238,360	1.00
2.00	SUBPROVIDER - IPF	123,282		123,282	2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	0		0	7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	63,361,642		63,361,642	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	27,524,058		27,524,058	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
14.01	NEONATAL INTENSIVE CARE	67,794,476		67,794,476	14.01
14.02	PEDIATRIC INTENSIVE CARE	716		716	14.02
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	95,319,250		95,319,250	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	158,680,892		158,680,892	17.00
18.00	Ancillary services	425,210,031	0	425,210,031	18.00
19.00	Outpatient services	19,450,888	648,488,637	667,939,525	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES	0	0	0	23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
24.20	OUTPATIENT PHYSICAL THERAPY	0	0	0	24.20
24.30	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	24.30
24.40	OUTPATIENT SPEECH PATHOLOGY	0	0	0	24.40
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	PHARM	0	3,574,525	3,574,525	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	603,341,811	652,063,162	1,255,404,973	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		348,641,161		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00	BAD DEBTS	0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00	PHYSICIAN PRACTICE REVENUE	0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		348,641,161		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0239

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

Worksheet G-3

Date/Time Prepared:
4/27/2022 12:54 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	1,255,404,973	1.00
2.00	Less contractual allowances and discounts on patients' accounts	891,340,254	2.00
3.00	Net patient revenues (line 1 minus line 2)	364,064,719	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	348,641,161	4.00
5.00	Net income from service to patients (line 3 minus line 4)	15,423,558	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER OPERATING INCOME	42,872,675	24.00
24.01	OTHER NON-OPERATING INCOME	0	24.01
24.02	PROVIDER TAX	0	24.02
24.50	COVID-19 PHE Funding	11,693,585	24.50
25.00	Total other income (sum of lines 6-24)	54,566,260	25.00
26.00	Total (line 5 plus line 25)	69,989,818	26.00
27.00	MISC	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	69,989,818	29.00

CALCULATION OF CAPITAL PAYMENT

Provider CCN: 14-0239

Period:
From 07/01/2020
To 06/30/2021Worksheet L
Parts I-III
Date/Time Prepared:
4/27/2022 12:54 pm

Title XVIII		Hospital	PPS
			1.00
PART I - FULLY PROSPECTIVE METHOD			
CAPITAL FEDERAL AMOUNT			
1.00	Capital DRG other than outlier	2,055,915	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	97,476	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)	130.95	3.00
4.00	Number of interns & residents (see instructions)	49.07	4.00
5.00	Indirect medical education percentage (see instructions)	11.15	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)	229,235	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	5.14	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	27.80	8.00
9.00	Sum of lines 7 and 8	32.94	9.00
10.00	Allowable disproportionate share percentage (see instructions)	6.90	10.00
11.00	Disproportionate share adjustment (see instructions)	141,858	11.00
12.00	Total prospective capital payments (see instructions)	2,524,484	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