

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). FORM APPROVED OMB NO. 0938-0050 EXPIRES 03-31-2022

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-0213	Period: From 10/01/2018 To 09/30/2019	Worksheet S Parts I-III Date/Time Prepared: 2/26/2020 4:51 am
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically filed cost report	Date: 2/26/2020	Time: 4:51 am
	2. ☐ Manually submitted cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☐ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by SILVER CROSS HOSPITAL (14-0213) for the cost reporting period beginning 10/01/2018 and ending 09/30/2019 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed)

Officer or Administrator of Provider(s)

Title

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	74,373	15,970	0	0	1.00
2.00	Subprovider - IPF	0	33,094	0		0	2.00
3.00	Subprovider - IRF	0	9,617	0		0	3.00
4.00	SUBPROVIDER I						4.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
8.00	NURSING FACILITY	0				0	8.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
12.00	CMHC I	0		0		0	12.00
200.00	Total	0	117,084	15,970	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0213		Period: From 10/01/2018 To 09/30/2019		Worksheet S-2 Part I Date/Time Prepared: 2/26/2020 4:51 am	
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 1900 SILVER CROSS BLVD.			PO Box:				1.00	
2.00	City: NEW LENOX			State: IL		Zip Code: 60451		County: WILL	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)	
								V	XVIII
								XIX	
		1.00		2.00	3.00	4.00	5.00	6.00	7.00
								8.00	
Hospital and Hospital-Based Component Identification:									
3.00	Hospital			SILVER CROSS HOSPITAL	140213	16974	1	07/01/1966	N
4.00	Subprovider - IPF			SCH - MENTAL HEALTH	14S213	16974	4	04/01/1991	N
5.00	Subprovider - IRF			CARE UNIT					
6.00	Subprovider - (Other)			SCH - REHAB	14T213	16974	5	10/01/2000	N
7.00	Swing Beds - SNF								
8.00	Swing Beds - NF								
9.00	Hospital-Based SNF								
10.00	Hospital-Based NF								
11.00	Hospital-Based OLTC								
12.00	Hospital-Based HHA			SCH HOME HEALTH	147452	16974		04/01/1994	N
13.00	Separately Certified ASC								
14.00	Hospital-Based Hospice								
15.00	Hospital-Based Health Clinic - RHC								
16.00	Hospital-Based Health Clinic - FQHC								
17.00	Hospital-Based (CMHC) I								
17.10	Hospital-Based (CORF) I								
18.00	Renal Dialysis								
19.00	Other								
							From:	To:	
							1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)						10/01/2018	09/30/2019	20.00
21.00	Type of Control (see instructions)						1		21.00
							1.00	2.00	3.00
Inpatient PPS Information									
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	Y		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					1	N		23.00
				In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days
				1.00	2.00	3.00	4.00	5.00	6.00
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.			2,242	1,796	0	0	6,678	603
									24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0213

Period:
From 10/01/2018
To 09/30/2019Worksheet S-2
Part I
Date/Time Prepared:
2/26/2020 4:51 am

		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	
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	83	0	0	88		25.00
						Urban/Rural S	Date of Geogr	
						1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					1		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					1		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00
						Beginning:	Ending:	
						1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00
						Y/N	Y/N	
						1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N	40.00
						V	XVIII	XIX
						1.00	2.00	3.00
Prospective Payment System (PPS)-Capital								
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	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.					N		
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.							
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N		
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		
				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 §413.85? (see instructions)					Y		60.00
60.01	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)						23.00	1

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

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From 10/01/2018
To 09/30/2019Worksheet S-2
Part I
Date/Time Prepared:
2/26/2020 4:51 am

	Y/N	IME	Direct GME	IME	Direct GME	
	1.00	2.00	3.00	4.00	5.00	
61.00 Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
	Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
	1.00		2.00	3.00	4.00	
61.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
					1.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings						
63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
		1.00	2.00	3.00		
64.00 Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. 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

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From 10/01/2018
To 09/30/2019Worksheet S-2
Part I
Date/Time Prepared:
2/26/2020 4:51 am

	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	
					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	0	71.00
Inpatient Rehabilitation Facility PPS							
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				Y		75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				N	0	76.00

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				1.00				
Long Term Care Hospital PPS								
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N	80.00			
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.			N	81.00			
TEFRA Providers								
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N	85.00			
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00			
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.			N	87.00			
			V	XIX				
			1.00	2.00				
Title V and XIX Services								
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N	Y	90.00		
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N	N	91.00		
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.				N	92.00		
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N	N	93.00		
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N	N	94.00		
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.			0.00	0.00	95.00		
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.			N	N	96.00		
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.			0.00	0.00	97.00		
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			Y	Y	98.00		
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			Y	Y	98.01		
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			Y	Y	98.02		
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			N	N	98.03		
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			N	N	98.04		
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			Y	Y	98.05		
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			Y	Y	98.06		
Rural Providers								
105.00	Does this hospital qualify as a CAH?			N		105.00		
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			N		106.00		
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.			N		107.00		
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			N		108.00		
			Physical	Occupational	Speech	Respiratory		
			1.00	2.00	3.00	4.00		
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.			N	N	N	N	109.00
						1.00		
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.				N			110.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0213	Period: From 10/01/2018 To 09/30/2019	Worksheet S-2 Part I Date/Time Prepared: 2/26/2020 4:51 am	
			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
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	0			118.00
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	0	0	0	
		1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N		N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y			121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N			122.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
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	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		HB2292	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0213		Period: From 10/01/2018 To 09/30/2019		Worksheet S-2 Part I Date/Time Prepared: 2/26/2020 4:51 am	
1.00		2.00		3.00					
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.									
141.00	Name: SILVER CROSS HOSPITAL HOME OFFICE		Contractor's Name: NGS		Contractor's Number: 06101				141.00
142.00	Street: 1900 SILVER CROSS BLVD.		PO Box:						142.00
143.00	City: NEW LENOX		State: IL		Zip Code: 60451				143.00
								1.00	
144.00 Are provider based physicians' costs included in Worksheet A?								Y	144.00
								1.00	2.00
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.				Y				145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.				N				146.00
								1.00	
147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.								N	147.00
148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.								N	148.00
149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.								N	149.00
				Part A	Part B	Title V	Title XIX		
				1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)									
155.00	Hospital			N	N	N	N		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
								1.00	
Multicampus									
165.00 Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.								N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus		
		0	1.00	2.00	3.00	4.00	5.00		
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00		
								1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00 Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.								Y	167.00
168.00 If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)									168.00
168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)									168.01
169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)								9.99	169.00
						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	0

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0213	Period: From 10/01/2018 To 09/30/2019	Worksheet S-2 Part II Date/Time Prepared: 2/26/2020 4:51 am
			Y/N 1.00	Date 2.00
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y		3.00
		Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N		5.00
			Y/N 1.00	Legal Oper. 2.00
Approved Educational Activities				
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	Y		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N 1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N	14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		Y	15.00
		Part A		Part B
		Y/N 1.00	Date 2.00	Y/N 3.00
				Date 4.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	02/05/2020	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0213

Period:
From 10/01/2018
To 09/30/2019Worksheet S-2
Part II
Date/Time Prepared:
2/26/2020 4:51 am

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?		Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.		Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.		N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.		N		40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	VINCE	PRYOR		41.00
42.00	Enter the employer/company name of the cost report preparer.	SILVER CROSS HOSPITAL			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	815-300-7011	VPRYOR@SILVERCROSS.ORG		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0213

Period:
From 10/01/2018
To 09/30/2019Worksheet S-2
Part II
Date/Time Prepared:
2/26/2020 4:51 am

		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	SENIOR VICE PRESIDENT & CFO		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0213

Period:
From 10/01/2018
To 09/30/2019Worksheet S-3
Part I
Date/Time Prepared:
2/26/2020 4:51 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	229	83,585	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)		229	83,585	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	30	10,416	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		259	94,001	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	0	3,520		0	16.00
17.00 SUBPROVIDER - IRF	41.00	25	9,125		0	17.00
18.00 SUBPROVIDER	42.00	0	0		0	18.00
19.00 SKILLED NURSING FACILITY	44.00	0	0		0	19.00
20.00 NURSING FACILITY	45.00	0	0		0	20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC	99.00				0	25.00
25.10 CMHC - CORF	99.10				0	25.10
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		284				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0213

Period:
From 10/01/2018
To 09/30/2019Worksheet S-3
Part I
Date/Time Prepared:
2/26/2020 4:51 am

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	25,420	3,188	58,611			1.00
2.00	HMO and other (see instructions)	8,299	6,678				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	672	88				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)	25,420	3,188	58,611			7.00
8.00	INTENSIVE CARE UNIT	3,370	439	8,067			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		411	7,557			13.00
14.00	Total (see instructions)	28,790	4,038	74,235	0.00	1,817.70	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	319	671	2,016	0.00	10.00	16.00
17.00	SUBPROVIDER - IRF	4,990	83	7,726	0.00	50.41	17.00
18.00	SUBPROVIDER		0	0	0.00	0.00	18.00
19.00	SKILLED NURSING FACILITY	0	0	0	0.00	0.00	19.00
20.00	NURSING FACILITY		0	0	0.00	0.00	20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	17,083	0	25,546	0.00	24.45	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC	0	0	0	0.00	0.00	25.00
25.10	CMHC - CORF	0	0	0	0.00	0.00	25.10
26.00	RURAL HEALTH CLINIC	0	0	0	0.00	0.00	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	1,902.56	27.00
28.00	Observation Bed Days		1,651	11,116			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	603	1,884			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0213

Period:
From 10/01/2018
To 09/30/2019Worksheet S-3
Part I
Date/Time Prepared:
2/26/2020 4:51 am

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	7,164	1,522	19,341	1.00
2.00 HMO and other (see instructions)			1,909	2,144		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				6		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	7,164	1,522	19,341	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	45	112	342	16.00
17.00 SUBPROVIDER - IRF	0.00	0	396	7	634	17.00
18.00 SUBPROVIDER	0.00	0		0	0	18.00
19.00 SKILLED NURSING FACILITY	0.00					19.00
20.00 NURSING FACILITY	0.00					20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0.00					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC	0.00					25.00
25.10 CMHC - CORF	0.00					25.10
26.00 RURAL HEALTH CLINIC	0.00					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0213

Period:
From 10/01/2018
To 09/30/2019Worksheet S-3
Part II
Date/Time Prepared:
2/26/2020 4:51 am

	Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	134,472,484	0	134,472,484	3,957,328.08	33.98
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		7,189,866	0	7,189,866	189,546.48	37.93
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		2,544,607	0	2,544,607	39,331.82	64.70
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		1,139,849	0	1,139,849	4,064.25	280.46
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		5,880,252	0	5,880,252	18,616.00	315.87
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
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		31,201,775	0	31,201,775		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		1,762,508	0	1,762,508		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		0	0	0		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0		
OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	1,120,772	0	1,120,772	28,847.20	38.85
27.00	Administrative & General	5.00	18,985,037	-312,306	18,672,731	581,620.05	32.10

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0213

Period:
From 10/01/2018
To 09/30/2019Worksheet S-3
Part II
Date/Time Prepared:
2/26/2020 4:51 am

		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		578,869	0	578,869	13,401.10	43.20	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	3,462,834	0	3,462,834	131,811.20	26.27	30.00
31.00	Laundry & Linen Service	8.00	68,748	0	68,748	4,278.40	16.07	31.00
32.00	Housekeeping	9.00	2,461,663	0	2,461,663	159,472.00	15.44	32.00
33.00	Housekeeping under contract (see instructions)		173,031	0	173,031	8,348.91	20.72	33.00
34.00	Dietary	10.00	2,354,067	-1,821,435	532,632	32,796.73	16.24	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	1,821,435	1,821,435	112,154.47	16.24	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	3,101,868	0	3,101,868	69,840.00	44.41	38.00
39.00	Central Services and Supply	14.00	1,755,782	-1,039,156	716,626	39,718.40	18.04	39.00
40.00	Pharmacy	15.00	3,886,131	0	3,886,131	79,296.00	49.01	40.00
41.00	Medical Records & Medical Records Library	16.00	2,906,855	0	2,906,855	97,478.40	29.82	41.00
42.00	Social Service	17.00	0	312,306	312,306	9,932.75	31.44	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0213

Period:
From 10/01/2018
To 09/30/2019Worksheet S-3
Part III
Date/Time Prepared:
2/26/2020 4:51 am

	Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	135,224,384	0	135,224,384	3,979,078.09	33.98	1.00
2.00	Excluded area salaries (see instructions)	7,189,866	0	7,189,866	189,546.48	37.93	2.00
3.00	Subtotal salaries (line 1 minus line 2)	128,034,518	0	128,034,518	3,789,531.61	33.79	3.00
4.00	Subtotal other wages & related costs (see inst.)	9,564,708	0	9,564,708	62,012.07	154.24	4.00
5.00	Subtotal wage-related costs (see inst.)	31,201,775	0	31,201,775	0.00	24.37	5.00
6.00	Total (sum of lines 3 thru 5)	168,801,001	0	168,801,001	3,851,543.68	43.83	6.00
7.00	Total overhead cost (see instructions)	40,855,657	-1,039,156	39,816,501	1,368,995.61	29.08	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 14-0213	Period: From 10/01/2018 To 09/30/2019	Worksheet S-3 Part IV Date/Time Prepared: 2/26/2020 4:51 am
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions			0 1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution			0 2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)		8,046,959	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)		0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration fees		0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan		0	6.00
7.00	Employee Managed Care Program Administration Fees		0	7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)		0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)		0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)		6,826,880	8.02
8.03	Health Insurance (Purchased)		4,908,526	8.03
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		590,307	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		139,389	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)		691,135	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		1,343,703	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		0	16.00
TAXES				
17.00	FICA-Employers Portion Only		9,971,296	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		60,000	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		386,088	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		32,964,283	24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)			25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 14-0213

Period:
From 10/01/2018
To 09/30/2019Worksheet S-3
Part V
Date/Time Prepared:
2/26/2020 4:51 am

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	2,544,607	32,964,283	1.00
2.00	Hospital	2,544,607	32,964,283	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	0	0	8.00
9.00	Hospital-Based NF	0	0	9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
15.00	Hospital-Based Health Clinic FQHC	0	0	15.00
16.00	Hospital-Based-CMHC	0	0	16.00
16.10	Hospital-Based-CMHC 10	0	0	16.10
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

Health Financial Systems		SILVER CROSS HOSPITAL			In Lieu of Form CMS-2552-10		
HOME HEALTH AGENCY STATISTICAL DATA				Provider CCN: 14-0213 Component CCN: 14-7452		Period: From 10/01/2018 To 09/30/2019	
				Home Health Agency I		Worksheet S-4 Date/Time Prepared: 2/26/2020 4:51 am	
						PPS	
				1.00			
0.00 County				WILL		0.00	
				Title V	Title XVIII	Title XIX	Other
				1.00	2.00	3.00	4.00
				Total		5.00	
HOME HEALTH AGENCY STATISTICAL DATA							
1.00	Home Health Aide Hours	0	2,648	11	294	2,953	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	759.00	40.00	839.00	1,638.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES							
3.00	Administrator and Assistant Administrator(s)	40.00		8.30	0.00	8.30	3.00
4.00	Director(s) and Assistant Director(s)			0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel			0.00	0.00	0.00	5.00
6.00	Direct Nursing Service			13.14	0.00	13.14	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			1.39	7.63	9.02	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			0.31	0.00	0.31	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.01	0.00	0.01	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.02	0.00	0.02	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			1.42	0.00	1.42	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	SOCIAL WORKER/REHAB REP			0.10	0.00	0.10	18.00
HOME HEALTH AGENCY CBSA CODES							
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			1			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).	16974					20.00
		Full Episodes		LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		Without Outliers	With Outliers				
		1.00	2.00	3.00	4.00	5.00	
PPS ACTIVITY DATA							
21.00	Skilled Nursing Visits	6,581	843	227	297	7,948	21.00
22.00	Skilled Nursing Visit Charges	1,601,320	203,958	55,851	73,203	1,934,332	22.00
23.00	Physical Therapy Visits	4,932	416	26	195	5,569	23.00
24.00	Physical Therapy Visit Charges	1,114,097	93,933	5,871	44,031	1,257,932	24.00
25.00	Occupational Therapy Visits	1,783	235	5	106	2,129	25.00
26.00	Occupational Therapy Visit Charges	402,601	53,063	1,129	23,483	480,276	26.00
27.00	Speech Pathology Visits	227	23	1	9	260	27.00
28.00	Speech Pathology Visit Charges	54,401	5,512	240	2,157	62,310	28.00
29.00	Medical Social Service Visits	66	8	2	5	81	29.00
30.00	Medical Social Service Visit Charges	21,764	2,638	660	1,649	26,711	30.00
31.00	Home Health Aide Visits	862	200	2	32	1,096	31.00
32.00	Home Health Aide Visit Charges	126,930	29,450	295	4,712	161,387	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	14,451	1,725	263	644	17,083	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	3,321,113	388,554	64,046	149,235	3,922,948	35.00
36.00	Total Number of Episodes (standard/non outlier)	798		85	25	908	36.00
37.00	Total Number of Outlier Episodes		46		13	59	37.00
38.00	Total Non-Routine Medical Supply Charges	9,136	3,262	107	672	13,177	38.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-0213	Period: From 10/01/2018 To 09/30/2019	Worksheet S-10 Date/Time Prepared: 2/26/2020 4:51 am	
				1.00	
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)			0.269718	1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid			27,887,776	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?			Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?			Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid			0	5.00
6.00	Medicaid charges			124,338,698	6.00
7.00	Medicaid cost (line 1 times line 6)			33,536,385	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)			5,648,609	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)			5,648,609	19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
Uncompensated Care (see instructions for each line)					
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	15,735,229	5,668,483	21,403,712	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	4,244,074	5,668,483	9,912,557	21.00
22.00	Payments received from patients for amounts previously written off as charity care	53,444	208,701	262,145	22.00
23.00	Cost of charity care (line 21 minus line 22)	4,190,630	5,459,782	9,650,412	23.00
				1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?			N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit			0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)			14,177,249	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			1,126,150	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			1,732,538	27.01
28.00	Non-Medicare bad debt expense (see instructions)			12,444,711	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			3,962,951	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			13,613,363	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			19,261,972	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0213

Period:
From 10/01/2018
To 09/30/2019

Worksheet A

Date/Time Prepared:
2/26/2020 4:51 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		51,489,158	51,489,158	-22,290,662	29,198,496	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	16,210,594	16,210,594	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,120,772	33,678,520	34,799,292	0	34,799,292	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	18,985,037	55,997,364	74,982,401	588,359	75,570,760	5.00
7.00	00700	OPERATION OF PLANT	3,462,834	6,677,382	10,140,216	0	10,140,216	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	68,748	138,571	207,319	0	207,319	8.00
9.00	00900	HOUSEKEEPING	2,461,663	1,554,975	4,016,638	0	4,016,638	9.00
10.00	01000	DIETARY	2,354,067	2,531,976	4,886,043	-3,780,525	1,105,518	10.00
11.00	01100	CAFETERIA	0	0	0	3,780,525	3,780,525	11.00
13.00	01300	NURSING ADMINISTRATION	3,101,868	70,996	3,172,864	0	3,172,864	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,755,782	2,364,999	4,120,781	-2,764,821	1,355,960	14.00
15.00	01500	PHARMACY	3,886,131	15,872,241	19,758,372	-13,197,517	6,560,855	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,906,855	579,909	3,486,764	0	3,486,764	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	312,306	312,306	17.00
23.00	02300	PARAMED ED PRGM	419,574	450,433	870,007	-413	869,594	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	25,070,118	3,681,116	28,751,234	5,737,577	34,488,811	30.00
31.00	03100	INTENSIVE CARE UNIT	6,846,372	1,550,809	8,397,181	655,362	9,052,543	31.00
40.00	04000	SUBPROVIDER - IPF	702,342	389,743	1,092,085	152,837	1,244,922	40.00
41.00	04100	SUBPROVIDER - IRF	3,819,006	625,677	4,444,683	97,116	4,541,799	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	9,906,406	811,648	10,718,054	-8,159,689	2,558,365	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	10,627,161	38,998,176	49,625,337	-25,616,465	24,008,872	50.00
51.00	05100	RECOVERY ROOM	1,450,114	102,928	1,553,042	-745	1,552,297	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	902,268	902,268	3,914,712	4,816,980	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,673,643	16,539,485	25,213,128	-10,984,461	14,228,667	54.00
54.01	05401	ULTRASOUND	1,261,719	328,105	1,589,824	-11,069	1,578,755	54.01
57.00	05700	CT SCAN	1,322,465	1,103,936	2,426,401	-54,559	2,371,842	57.00
58.00	05800	MRI	735,816	488,137	1,223,953	0	1,223,953	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	4,185,304	6,668,972	10,854,276	96,961	10,951,237	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	302,141	1,506,398	1,808,539	0	1,808,539	63.00
65.00	06500	RESPIRATORY THERAPY	1,964,943	381,041	2,345,984	82,077	2,428,061	65.00
65.01	06501	SLEEP LAB	252,663	185,241	437,904	110,000	547,904	65.01
66.00	06600	PHYSICAL THERAPY	1,446,483	382,258	1,828,741	-2,424	1,826,317	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,732,051	382,406	2,114,457	-1,664	2,112,793	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,425,141	216,228	1,641,369	367,800	2,009,169	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	131,110	31,922	163,032	1,349,400	1,512,432	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	15,937,483	15,937,483	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	23,671,734	23,671,734	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	13,167,965	13,167,965	73.00
74.00	07400	RENAL DIALYSIS	451,463	168,974	620,437	10,469	630,906	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	661,475	238,612	900,087	212,642	1,112,729	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	8,260,836	3,109,183	11,370,019	440,810	11,810,829	91.00
91.01	09101	OP MENTAL HEALTH	177,359	3,561	180,920	0	180,920	91.01
91.02	09102	DIABETES CENTER	294,078	4,851	298,929	-55,593	243,336	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	2,233,648	1,239,623	3,473,271	23,878	3,497,149	101.00
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	134,457,188	251,447,822	385,905,010	0	385,905,010	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	15,296	0	15,296	0	15,296	190.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0213

Period:
From 10/01/2018
To 09/30/2019

Worksheet A

Date/Time Prepared:
2/26/2020 4:51 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		TOTAL (SUM OF LINES 118 through 199)	134,472,484	251,447,822	385,920,306	0	385,920,306	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0213

Period:
From 10/01/2018
To 09/30/2019

Worksheet A

Date/Time Prepared:
2/26/2020 4:51 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-5,340,490	23,858,006	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	16,210,594	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-77,476	34,721,816	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-22,665,308	52,905,452	5.00
7.00	00700	OPERATION OF PLANT	-280	10,139,936	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	207,319	8.00
9.00	00900	HOUSEKEEPING	0	4,016,638	9.00
10.00	01000	DIETARY	0	1,105,518	10.00
11.00	01100	CAFETERIA	-2,279,579	1,500,946	11.00
13.00	01300	NURSING ADMINISTRATION	-41,375	3,131,489	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-22,723	1,333,237	14.00
15.00	01500	PHARMACY	-3,100	6,557,755	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-1,224	3,485,540	16.00
17.00	01700	SOCIAL SERVICE	0	312,306	17.00
23.00	02300	PARAMED ED PRGM	-283,303	586,291	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-1,837,073	32,651,738	30.00
31.00	03100	INTENSIVE CARE UNIT	-722,170	8,330,373	31.00
40.00	04000	SUBPROVIDER - IPF	-149,383	1,095,539	40.00
41.00	04100	SUBPROVIDER - IRF	-110,483	4,431,316	41.00
42.00	04200	SUBPROVIDER	0	0	42.00
43.00	04300	NURSERY	-4,029	2,554,336	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	45.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	24,008,872	50.00
51.00	05100	RECOVERY ROOM	0	1,552,297	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	4,816,980	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,890,291	17,118,958	54.00
54.01	05401	ULTRASOUND	0	1,578,755	54.01
57.00	05700	CT SCAN	0	2,371,842	57.00
58.00	05800	MRI	0	1,223,953	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	-20,488	10,930,749	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	1,808,539	63.00
65.00	06500	RESPIRATORY THERAPY	-76,337	2,351,724	65.00
65.01	06501	SLEEP LAB	-110,000	437,904	65.01
66.00	06600	PHYSICAL THERAPY	0	1,826,317	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,112,793	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	-391,668	1,617,501	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	-1,346,077	166,355	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	15,937,483	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	23,671,734	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	13,167,965	73.00
74.00	07400	RENAL DIALYSIS	-4,966	625,940	74.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	1,497,959	2,610,688	90.00
90.01	09001	HOMER GLEN LAB	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0	0	90.03
91.00	09100	EMERGENCY	-1,026,842	10,783,987	91.00
91.01	09101	OP MENTAL HEALTH	0	180,920	91.01
91.02	09102	DIABETES CENTER	0	243,336	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
94.00	09400	HOME PROGRAM DIALYSIS	0	0	94.00
99.00	09900	CMHC	0	0	99.00
99.10	09910	CORF	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	3,497,149	101.00
SPECIAL PURPOSE COST CENTERS					
109.00	10900	PANCREAS ACQUISITION	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-32,126,124	353,778,886	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	15,296	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-32,126,124	353,794,182	200.00

RECLASSIFICATIONS

Provider CCN: 14-0213

Period:
From 10/01/2018
To 09/30/2019

Worksheet A-6

Date/Time Prepared:
2/26/2020 4:51 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - STERILE PROCESSING					
1.00	ADULTS & PEDIATRICS	30.00	14,548	24,022		1.00
2.00	OPERATING ROOM	50.00	931,084	1,537,438		2.00
3.00	DELIVERY ROOM & LABOR ROOM	52.00	65,467	108,101		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	7,274	12,011		4.00
5.00	CLINIC	90.00	4,157	6,864		5.00
6.00	EMERGENCY	91.00	16,626	27,454		6.00
	0		1,039,156	1,715,890		
	C - CAPITAL INSURANCE					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	209,097		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	229,808		2.00
	0		0	438,905		
	D - CHARGEABLE DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	13,167,965		1.00
2.00		0.00	0	0		2.00
	0		0	13,167,965		
	E - MALPRACTICE INSURANCE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	5,850,260		1.00
	0		0	5,850,260		
	F - DEPRECIATION					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	16,001,497		1.00
	0		0	16,001,497		
	G - PHYSICIAN FEES					
1.00	ADULTS & PEDIATRICS	30.00	0	1,883,844		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	754,027		2.00
3.00	SUBPROVIDER - IPF	40.00	0	152,842		3.00
4.00	SUBPROVIDER - IRF	41.00	0	110,483		4.00
5.00	OPERATING ROOM	50.00	0	38,000		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	44,000		6.00
7.00	LABORATORY	60.00	0	100,000		7.00
8.00	RESPIRATORY THERAPY	65.00	0	87,582		8.00
9.00	SLEEP LAB	65.01	0	110,000		9.00
10.00	ELECTROCARDIOLOGY	69.00	0	367,800		10.00
11.00	ELECTROENCEPHALOGRAPHY	70.00	0	1,357,067		11.00
12.00	RENAL DIALYSIS	74.00	0	11,100		12.00
13.00	CLINIC	90.00	0	236,698		13.00
14.00	EMERGENCY	91.00	0	467,900		14.00
15.00	DIABETES CENTER	91.02	0	5,004		15.00
16.00	HOME HEALTH AGENCY	101.00	0	32,008		16.00
	0		0	5,758,355		
	H - LABOR AND DELIVERY					
1.00	ADULTS & PEDIATRICS	30.00	3,988,516	0		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	4,159,821	0		2.00
	0		8,148,337	0		
	I - SOCIAL SERVICES					
1.00	SOCIAL SERVICE	17.00	312,306	0		1.00
	0		312,306	0		
	K - CHARGEABLE SUPPLIES					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	579,852		1.00
2.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	15,937,483		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
	0		0	16,517,335		

RECLASSIFICATIONS

Provider CCN: 14-0213

Period:
From 10/01/2018
To 09/30/2019

Worksheet A-6

Date/Time Prepared:
2/26/2020 4:51 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
1.00	L - DIABETES MANAGEMENT					1.00
	ADULTS & PEDIATRICS	30.00	59,038	974		
			59,038	974		
1.00	M - DIETARY RECLASS					1.00
	CAFETERIA	11.00	1,821,435	1,959,090		
			1,821,435	1,959,090		
1.00	N - IMPLANTABLE DEVICES					1.00
	IMPL. DEV. CHARGED TO	72.00	0	23,671,734		
	PATIENTS					
2.00		0.00	0	0	2.00	
			0	23,671,734		
500.00	Grand Total: Increases		11,380,272	85,082,005	500.00	

RECLASSIFICATIONS

Provider CCN: 14-0213

Period:
From 10/01/2018
To 09/30/2019Worksheet A-6
Date/Time Prepared:
2/26/2020 4:51 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - STERILE PROCESSING						
1.00	CENTRAL SERVICES & SUPPLY	14.00	1,039,156	1,715,890	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
	0		1,039,156	1,715,890			
	C - CAPITAL INSURANCE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	438,905	9		1.00
2.00		0.00	0	0	0		2.00
	0		0	438,905			
	D - CHARGEABLE DRUGS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	900	0		1.00
2.00	PHARMACY	15.00	0	13,167,065	0		2.00
	0		0	13,167,965			
	E - MALPRACTICE INSURANCE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	5,850,260	9		1.00
	0		0	5,850,260			
	F - DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	16,001,497	9		1.00
	0		0	16,001,497			
	G - PHYSICIAN FEES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	5,758,355	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
16.00		0.00	0	0	0		16.00
	0		0	5,758,355			
	H - LABOR AND DELIVERY						
1.00	NURSERY	43.00	8,148,337	0	0		1.00
2.00		0.00	0	0	0		2.00
	0		8,148,337	0			
	I - SOCIAL SERVICES						
1.00	ADMINISTRATIVE & GENERAL	5.00	312,306	0	0		1.00
	0		312,306	0			
	K - CHARGEABLE SUPPLIES						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	9,775	0		1.00
2.00	PHARMACY	15.00	0	30,452	0		2.00
3.00	PARAMED ED PRGM	23.00	0	413	0		3.00
4.00	ADULTS & PEDIATRICS	30.00	0	233,365	0		4.00
5.00	INTENSIVE CARE UNIT	31.00	0	98,665	0		5.00
6.00	SUBPROVIDER - IPF	40.00	0	5	0		6.00
7.00	SUBPROVIDER - IRF	41.00	0	13,367	0		7.00
8.00	NURSERY	43.00	0	11,352	0		8.00
9.00	OPERATING ROOM	50.00	0	10,408,564	0		9.00
10.00	RECOVERY ROOM	51.00	0	745	0		10.00
11.00	DELIVERY ROOM & LABOR ROOM	52.00	0	418,677	0		11.00
12.00	RADIOLOGY-DIAGNOSTIC	54.00	0	5,090,435	0		12.00
13.00	ULTRASOUND	54.01	0	11,069	0		13.00
14.00	CT SCAN	57.00	0	54,559	0		14.00
15.00	LABORATORY	60.00	0	3,039	0		15.00
16.00	RESPIRATORY THERAPY	65.00	0	5,505	0		16.00
17.00	PHYSICAL THERAPY	66.00	0	2,424	0		17.00
18.00	OCCUPATIONAL THERAPY	67.00	0	1,664	0		18.00
19.00	ELECTROENCEPHALOGRAPHY	70.00	0	7,667	0		19.00
20.00	RENAL DIALYSIS	74.00	0	631	0		20.00
21.00	CLINIC	90.00	0	35,077	0		21.00
22.00	EMERGENCY	91.00	0	71,170	0		22.00
23.00	DIABETES CENTER	91.02	0	585	0		23.00
24.00	HOME HEALTH AGENCY	101.00	0	8,130	0		24.00
	0		0	16,517,335			

RECLASSIFICATIONS

Provider CCN: 14-0213

Period:
From 10/01/2018
To 09/30/2019

Worksheet A-6

Date/Time Prepared:
2/26/2020 4:51 am

	Decreases						2/26/2025 4:01 am
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
1.00	L - DIABETES MANAGEMENT						
	DIABETES CENTER	91.02	59,038	974	0		1.00
	0		59,038	974			
1.00	M - DIETARY RECLASS						
	DIETARY	10.00	1,821,435	1,959,090	0		1.00
	0		1,821,435	1,959,090			
1.00	N - IMPLANTABLE DEVICES						
	RADIOLOGY-DIAGNOSTIC	54.00	0	5,957,311	0		1.00
2.00	OPERATING ROOM	50.00	0	17,714,423	0		2.00
	0		0	23,671,734			
500.00	Grand Total: Decreases		11,380,272	85,082,005			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0213

Period:
From 10/01/2018
To 09/30/2019Worksheet A-7
Part I
Date/Time Prepared:
2/26/2020 4:51 am

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	19,840,244	632,560	0	632,560	0	1.00	
2.00	Land Improvements	14,797,962	593,181	0	593,181	0	2.00	
3.00	Buildings and Fixtures	333,260,750	0	0	0	0	3.00	
4.00	Building Improvements	16,391,199	1,856,448	0	1,856,448	0	4.00	
5.00	Fixed Equipment	18,740,883	173,298	0	173,298	0	5.00	
6.00	Movable Equipment	233,148,929	0	0	0	4,207,610	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	636,179,967	3,255,487	0	3,255,487	4,207,610	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	636,179,967	3,255,487	0	3,255,487	4,207,610	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	20,472,804	0					1.00
2.00	Land Improvements	15,391,143	0					
3.00	Buildings and Fixtures	333,260,750	0					
4.00	Building Improvements	18,247,647	0					4.00
5.00	Fixed Equipment	18,914,181	0					
6.00	Movable Equipment	228,941,319	0					
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	635,227,844	0					
9.00	Reconciling Items	0	0					
10.00	Total (line 8 minus line 9)	635,227,844	0					10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0213

Period:
From 10/01/2018
To 09/30/2019Worksheet A-7
Part II
Date/Time Prepared:
2/26/2020 4:51 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	28,669,922	172,000	15,920,877	6,464,090	262,269	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	28,669,922	172,000	15,920,877	6,464,090	262,269	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	51,489,158				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	51,489,158				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0213

Period:
From 10/01/2018
To 09/30/2019Worksheet A-7
Part III
Date/Time Prepared:
2/26/2020 4:51 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	406,286,525	0	406,286,525	0.639592	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	228,941,319	0	228,941,319	0.360408	0	2.00
3.00	Total (sum of lines 1-2)	635,227,844	0	635,227,844	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	4,641,986	172,000	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	16,210,594	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	20,852,580	172,000	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	12,317,661	6,464,090	262,269	0	23,858,006	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	16,210,594	2.00
3.00	Total (sum of lines 1-2)	12,317,661	6,464,090	262,269	0	40,068,600	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0213

Period:
From 10/01/2018
To 09/30/2019

Worksheet A-8

Date/Time Prepared:
2/26/2020 4:51 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-9,382,874			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	3,287,188			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)			0*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT			0CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP			0CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist			0*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant			0	0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)			0ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest			0	0.00	0	32.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0213

Period:
From 10/01/2018
To 09/30/2019

Worksheet A-8

Date/Time Prepared:
2/26/2020 4:51 am

			Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	1.00	2.00	3.00	4.00	5.00	
33.00 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.00
33.01 1996 DSR INTEXP	A	14,351	CAP REL COSTS-BLDG & FIXT	1.00	9	33.01
33.02 PROVIDER TAX ASSESSMENT IN A&G	B	-16,128,392	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03 ADMINISTRATIVE MISC	B	-176,030	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04 PHYSICIANS	A	-150,000	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05 CONTRIBUTIONS EXPENSE	B	-129,272	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06 BAD DEBTS	A	427,133	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07 TELEPHONE BENEFITS	B	-20,568	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.07
33.08 TELEPHONE COSTS	A	-73,118	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09 COMMUNITY RELATIONS	A	-1,349,778	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10 OTHER REV - CAPITAL EXPENSE	B	-1,751,625	CAP REL COSTS-BLDG & FIXT	1.00	9	33.10
33.11 OTHER REV - EMPLOYEE BENEFIS	B	-56,908	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.11
33.12 OTHER REV A & G	B	305,677	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13 OTHER REV - OPERATION & PLANT	B	-280	OPERATION OF PLANT	7.00	0	33.13
33.14 OTHER REV - CAF'-EMP & GUESTS	B	-2,271,298	CAFETERIA	11.00	0	33.14
33.15 OTHER REV - VENDING MACHINES	B	-8,281	CAFETERIA	11.00	0	33.15
33.16 OTHER REVENUE-CENTRAL SUPPLY	B	-22,723	CENTRAL SERVICES & SUPPLY	14.00	0	33.16
33.17 OTHER REV - PHARMACY	B	-3,100	PHARMACY	15.00	0	33.17
33.18 OTHER REV - MED REC	B	-1,224	MEDICAL RECORDS & LIBRARY	16.00	0	33.18
33.19 OTHER REV - PARAMED ED PROGRAM	B	-283,303	PARAMED ED PRGM	23.00	0	33.19
33.20 OTHER REV - A & P	B	0	ADULTS & PEDIATRICS	30.00	0	33.20
33.21 OTHER REV - ADULTS & PEDS	B	0	INTENSIVE CARE UNIT	31.00	0	33.21
33.22 OTHER REV - REHAB	B	0	SUBPROVIDER - IRF	41.00	0	33.22
33.23 OTHER REV - NURSERY	B	-4,029	NURSERY	43.00	0	33.23
33.24 OTHER REV - OPERATING ROOM	B	0	OPERATING ROOM	50.00	0	33.24
33.25 OTHER REV - RADIOLOGY	B	-6,439	RADIOLOGY-DIAGNOSTIC	54.00	0	33.25
33.26 OTHER REV - LAB	B	-10,707	LABORATORY	60.00	0	33.26
33.27 OTHER REV - CARDIAC CATH	B	-35,625	ELECTROCARDIOLOGY	69.00	0	33.27
33.28 OTHER REV - CLINIC	B	0	CLINIC	90.00	0	33.28
33.29 OTHER REV - ER	B	-605,457	EMERGENCY	91.00	0	33.29
33.30 OTHER REV - PSYCH	B	0	OP MENTAL HEALTH	91.01	0	33.30
33.31 INVESTMENT INCOME	B	-3,603,216	CAP REL COSTS-BLDG & FIXT	1.00	11	33.31
33.32 AHA & IHA DUES-POLITICAL LOBBY	B	-44,851	ADMINISTRATIVE & GENERAL	5.00	0	33.32
33.33 OTHER REV - NURSING ADMIN	B	-41,375	NURSING ADMINISTRATION	13.00	0	33.33
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-32,126,124				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

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

Provider CCN: 14-0213

Period:
From 10/01/2018
To 09/30/2019

Worksheet A-8-1

Date/Time Prepared:
2/26/2020 4:51 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	MANAGEMENT FEE	7,160,945	8,528,868	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	JV OPERATING EXP	2,922,499	0	2.00
3.00	90.00	CLINIC	JV OPERATING EXP	1,732,612	0	3.00
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			11,816,056	8,528,868	5.00

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

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

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

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

6.00	G	SILVER CROSS HO	100.00	SILVER CROSS HO	100.00	6.00
7.00	C	UCMS/SCH ONC JV	60.00	UCMS/SCH ONC JV	60.00	7.00
8.00	C	OP SURGERY JV	24.95	OP SURGERY JV	24.95	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
		HOME OFFICE				

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

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

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

Provider CCN: 14-0213

Period:
From 10/01/2018
To 09/30/2019

Worksheet A-8-1

Date/Time Prepared:
2/26/2020 4:51 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	-1,367,923	0		1.00
2.00	2,922,499	0		2.00
3.00	1,732,612	0		3.00
4.00	0	0		4.00
5.00	3,287,188			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	RADIOLOGY ONCOL		7.00
8.00	CLINIC		8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0213

Period:
From 10/01/2018
To 09/30/2019

Worksheet A-8-2

Date/Time Prepared:
2/26/2020 4:51 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	3,978,754	3,978,754	0	211,500	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	1,883,844	1,697,882	185,962	177,200	549	2.00
3.00	31.00	INTENSIVE CARE UNIT	754,027	694,027	60,000	154,100	430	3.00
4.00	40.00	SUBPROVIDER - IPF	152,842	149,383	3,459	154,100	101	4.00
5.00	41.00	SUBPROVIDER - IRF	110,483	110,483	0	208,000	0	5.00
6.00	50.00	OPERATING ROOM	38,000	0	38,000	177,200	558	6.00
7.00	65.00	RESPIRATORY THERAPY	87,582	70,000	17,582	177,200	132	7.00
8.00	69.00	ELECTROCARDIOLOGY	367,800	347,800	20,000	177,200	138	8.00
9.00	70.00	ELECTROENCEPHALOGRAPHY	1,357,067	784,900	572,167	177,200	129	9.00
10.00	74.00	RENAL DIALYSIS	11,100	0	11,100	177,200	72	10.00
11.00	90.00	CLINIC	236,698	233,792	2,906	177,200	24	11.00
12.00	91.00	EMERGENCY	467,900	388,230	79,670	177,200	546	12.00
13.00	65.01	SLEEP LAB	110,000	110,000	0	215,700	0	13.00
14.00	60.00	LABORATORY	100,000	0	100,000	177,200	1,059	14.00
15.00	91.02	DIABETES CENTER	5,004	0	5,004	177,200	113	15.00
16.00	54.00	RADIOLOGY-DIAGNOSTIC	44,000	0	44,000	177,200	214	16.00
200.00			9,705,101	8,565,251	1,139,850		4,065	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	46,771	2,339	0	0	0	2.00
3.00	31.00	INTENSIVE CARE UNIT	31,857	1,593	0	0	0	3.00
4.00	40.00	SUBPROVIDER - IPF	7,483	374	0	0	0	4.00
5.00	41.00	SUBPROVIDER - IRF	0	0	0	0	0	5.00
6.00	50.00	OPERATING ROOM	47,537	2,377	0	0	0	6.00
7.00	65.00	RESPIRATORY THERAPY	11,245	562	0	0	0	7.00
8.00	69.00	ELECTROCARDIOLOGY	11,757	588	0	0	0	8.00
9.00	70.00	ELECTROENCEPHALOGRAPHY	10,990	550	0	0	0	9.00
10.00	74.00	RENAL DIALYSIS	6,134	307	0	0	0	10.00
11.00	90.00	CLINIC	2,045	102	0	0	0	11.00
12.00	91.00	EMERGENCY	46,515	2,326	0	0	0	12.00
13.00	65.01	SLEEP LAB	0	0	0	0	0	13.00
14.00	60.00	LABORATORY	90,219	4,511	0	0	0	14.00
15.00	91.02	DIABETES CENTER	9,627	481	0	0	0	15.00
16.00	54.00	RADIOLOGY-DIAGNOSTIC	18,231	912	0	0	0	16.00
200.00			340,411	17,022	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	3,978,754		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	46,771	139,191	1,837,073		2.00
3.00	31.00	INTENSIVE CARE UNIT	0	31,857	28,143	722,170		3.00
4.00	40.00	SUBPROVIDER - IPF	0	7,483	0	149,383		4.00
5.00	41.00	SUBPROVIDER - IRF	0	0	0	110,483		5.00
6.00	50.00	OPERATING ROOM	0	47,537	0	0		6.00
7.00	65.00	RESPIRATORY THERAPY	0	11,245	6,337	76,337		7.00
8.00	69.00	ELECTROCARDIOLOGY	0	11,757	8,243	356,043		8.00
9.00	70.00	ELECTROENCEPHALOGRAPHY	0	10,990	561,177	1,346,077		9.00
10.00	74.00	RENAL DIALYSIS	0	6,134	4,966	4,966		10.00
11.00	90.00	CLINIC	0	2,045	861	234,653		11.00
12.00	91.00	EMERGENCY	0	46,515	33,155	421,385		12.00
13.00	65.01	SLEEP LAB	0	0	0	110,000		13.00
14.00	60.00	LABORATORY	0	90,219	9,781	9,781		14.00
15.00	91.02	DIABETES CENTER	0	9,627	0	0		15.00
16.00	54.00	RADIOLOGY-DIAGNOSTIC	0	18,231	25,769	25,769		16.00
200.00			0	340,411	817,623	9,382,874		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0213

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part I
Date/Time Prepared:
2/26/2020 4:51 am

Cost Center Description			Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	23,858,006	23,858,006				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	16,210,594		16,210,594			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	34,721,816	88,405	63	34,810,284		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	52,905,452	5,483,705	9,187,144	4,874,348	72,450,649	5.00
7.00	00700	OPERATION OF PLANT	10,139,936	293,545	116,448	903,942	11,453,871	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	207,319	100,972	0	17,946	326,237	8.00
9.00	00900	HOUSEKEEPING	4,016,638	250,328	14,649	642,595	4,924,210	9.00
10.00	01000	DIETARY	1,105,518	994,875	4,447	139,039	2,243,879	10.00
11.00	01100	CAFETERIA	1,500,946	0	15,207	475,469	1,991,622	11.00
13.00	01300	NURSING ADMINISTRATION	3,131,489	125,930	74,808	809,715	4,141,942	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,333,237	802,784	223,473	187,069	2,546,563	14.00
15.00	01500	PHARMACY	6,557,755	331,377	289,425	1,014,440	8,192,997	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,485,540	46,895	1,619	758,808	4,292,862	16.00
17.00	01700	SOCIAL SERVICE	312,306	0	0	81,525	393,831	17.00
23.00	02300	PARAMED ED PRGM	586,291	36,693	21,804	109,526	754,314	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	32,651,738	5,159,769	260,993	7,604,725	45,677,225	30.00
31.00	03100	INTENSIVE CARE UNIT	8,330,373	743,409	264,108	1,787,184	11,125,074	31.00
40.00	04000	SUBPROVIDER - IPF	1,095,539	485,112	9,291	183,340	1,773,282	40.00
41.00	04100	SUBPROVIDER - IRF	4,431,316	883,088	23,319	996,917	6,334,640	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	2,554,336	1,993,385	100,586	458,928	5,107,235	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	24,008,872	2,403,884	2,995,073	3,017,176	32,425,005	50.00
51.00	05100	RECOVERY ROOM	1,552,297	189,902	1,604	378,539	2,122,342	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,816,980	0	186,827	1,102,973	6,106,780	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	17,118,958	1,073,385	1,165,159	2,266,075	21,623,577	54.00
54.01	05401	ULTRASOUND	1,578,755	131,447	85,769	329,360	2,125,331	54.01
57.00	05700	CT SCAN	2,371,842	117,917	333,335	345,218	3,168,312	57.00
58.00	05800	MRI	1,223,953	152,027	133,460	192,078	1,701,518	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	10,930,749	26,228	135,837	1,092,536	12,185,350	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,808,539	0	12,550	78,871	1,899,960	63.00
65.00	06500	RESPIRATORY THERAPY	2,351,724	86,041	52,509	512,931	3,003,205	65.00
65.01	06501	SLEEP LAB	437,904	0	1,807	65,955	505,666	65.01
66.00	06600	PHYSICAL THERAPY	1,826,317	10,903	5,136	377,591	2,219,947	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,112,793	0	30,103	452,136	2,595,032	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,617,501	63,753	163,485	372,020	2,216,759	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	166,355	45,538	22,206	34,225	268,324	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	15,937,483	0	0	0	15,937,483	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	23,671,734	0	0	0	23,671,734	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,167,965	0	0	0	13,167,965	73.00
74.00	07400	RENAL DIALYSIS	625,940	126,806	17,061	117,850	887,657	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	2,610,688	0	2,121	173,757	2,786,566	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	10,783,987	1,396,399	257,713	2,160,757	14,598,856	91.00
91.01	09101	OP MENTAL HEALTH	180,920	134,294	0	46,298	361,512	91.01
91.02	09102	DIABETES CENTER	243,336	0	265	61,355	304,956	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	3,497,149	0	1,190	583,074	4,081,413	101.00
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0213

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part I
Date/Time Prepared:
2/26/2020 4:51 am

Cost Center Description			Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	353,778,886	23,778,796	16,210,594	34,806,291	353,695,683	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	15,296	79,210	0	3,993	98,499	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	353,794,182	23,858,006	16,210,594	34,810,284	353,794,182	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0213

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part I
Date/Time Prepared:
2/26/2020 4:51 am

Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	72,450,649					5.00
7.00	00700	OPERATION OF PLANT	2,949,566	14,403,437				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	84,012	80,831	491,080			8.00
9.00	00900	HOUSEKEEPING	1,268,068	200,395	0	6,392,673		9.00
10.00	01000	DIETARY	577,837	796,429	0	360,518	3,978,663	10.00
11.00	01100	CAFETERIA	512,877	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,066,620	100,811	0	45,634	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	655,783	642,653	63	290,909	0	14.00
15.00	01500	PHARMACY	2,109,836	265,278	0	120,083	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,105,485	37,541	0	16,994	0	16.00
17.00	01700	SOCIAL SERVICE	101,418	0	0	0	0	17.00
23.00	02300	PARAMED ED PRGM	194,249	29,374	11,899	13,297	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	11,762,568	4,130,557	196,782	1,869,767	2,426,786	30.00
31.00	03100	INTENSIVE CARE UNIT	2,864,896	595,122	33,612	269,393	792,284	31.00
40.00	04000	SUBPROVIDER - IPF	456,650	388,347	1,552	175,792	83,302	40.00
41.00	04100	SUBPROVIDER - IRF	1,631,277	706,940	7,556	320,009	676,291	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	1,315,200	1,595,767	0	722,353	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	8,349,990	1,924,384	83,227	871,107	0	50.00
51.00	05100	RECOVERY ROOM	546,539	152,023	16,676	68,816	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,572,600	0	26,078	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,568,439	859,278	23,716	388,968	0	54.00
54.01	05401	ULTRASOUND	547,309	105,228	3,676	47,633	0	54.01
57.00	05700	CT SCAN	815,894	94,396	3,676	42,730	0	57.00
58.00	05800	MRI	438,170	121,702	5,691	55,091	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	3,137,935	20,996	0	9,504	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	489,272	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	773,376	68,878	0	31,179	0	65.00
65.01	06501	SLEEP LAB	130,218	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	571,674	8,728	0	3,951	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	668,265	0	6,225	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	570,853	51,036	411	23,103	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	69,098	36,455	0	16,502	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,104,173	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,095,874	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,390,975	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	228,587	101,512	0	45,951	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	717,588	0	197	0	0	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	3,759,454	1,117,860	70,043	506,020	0	91.00
91.01	09101	OP MENTAL HEALTH	93,095	107,506	0	48,665	0	91.01
91.02	09102	DIABETES CENTER	78,531	0	0	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	1,051,033	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	72,425,284	14,340,027	491,080	6,363,969	3,978,663	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	25,365	63,410	0	28,704	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0213

Period:
From 10/01/2018
To 09/30/2019Worksheet B
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Date/Time Prepared:
2/26/2020 4:51 am

Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	72,450,649	14,403,437	491,080	6,392,673	3,978,663	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0213

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part I
Date/Time Prepared:
2/26/2020 4:51 am

Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	2,504,499					11.00
13.00	01300	NURSING ADMINISTRATION	62,155	5,417,162				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	74,952	0	4,210,923			14.00
15.00	01500	PHARMACY	69,468	0	41,926	10,799,588		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	85,921	0	1,684	0	5,540,487	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
23.00	02300	PARAMED ED PRGM	10,969	0	20,756	56,822	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	645,320	3,021,860	320,267	3,239	2,192,645	30.00
31.00	03100	INTENSIVE CARE UNIT	142,592	669,922	121,143	21,851	674,922	31.00
40.00	04000	SUBPROVIDER - IPF	18,281	0	1,392	0	176,135	40.00
41.00	04100	SUBPROVIDER - IRF	91,405	431,566	20,473	0	171,294	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	215,716	1,013,786	28,776	0	236,792	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	246,794	0	519,314	0	0	50.00
51.00	05100	RECOVERY ROOM	25,593	0	5,114	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	46,463	955	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	202,919	0	219,888	18,679	0	54.00
54.01	05401	ULTRASOUND	27,422	0	17,715	0	0	54.01
57.00	05700	CT SCAN	31,078	0	41,096	0	0	57.00
58.00	05800	MRI	14,625	0	7,215	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	120,655	0	543,002	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	7,312	0	21,475	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	53,015	0	35,051	0	0	65.00
65.01	06501	SLEEP LAB	9,141	0	4,274	0	0	65.01
66.00	06600	PHYSICAL THERAPY	31,078	0	987	0	510,036	66.00
67.00	06700	OCCUPATIONAL THERAPY	40,218	0	5,283	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	34,734	0	4,631	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	3,656	0	949	0	118,467	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	1,983,426	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	10,689,848	0	73.00
74.00	07400	RENAL DIALYSIS	7,312	36,046	14,102	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	12,797	0	11,363	0	22,355	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	204,747	0	160,175	8,194	1,437,841	91.00
91.01	09101	OP MENTAL HEALTH	5,484	0	398	0	0	91.01
91.02	09102	DIABETES CENTER	7,312	34,663	420	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	209,319	12,165	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,502,671	5,417,162	4,210,923	10,799,588	5,540,487	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,828	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0213

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part I
Date/Time Prepared:
2/26/2020 4:51 am

Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	2,504,499	5,417,162	4,210,923	10,799,588	5,540,487	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0213

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part I
Date/Time Prepared:
2/26/2020 4:51 am

Cost Center Description			SOCIAL SERVICE	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	23.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	495,249					17.00
23.00	02300	PARAMED ED PRGM	0	1,091,680				23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	430,178	0	72,677,194	0	72,677,194	30.00
31.00	03100	INTENSIVE CARE UNIT	26,380	0	17,337,191	0	17,337,191	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	3,074,733	0	3,074,733	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	10,391,451	0	10,391,451	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	10,235,625	0	10,235,625	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	44,419,821	0	44,419,821	50.00
51.00	05100	RECOVERY ROOM	0	0	2,937,103	0	2,937,103	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	49,355	7,802,231	0	7,802,231	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	28,905,464	0	28,905,464	54.00
54.01	05401	ULTRASOUND	0	0	2,874,314	0	2,874,314	54.01
57.00	05700	CT SCAN	0	0	4,197,182	0	4,197,182	57.00
58.00	05800	MRI	0	0	2,344,012	0	2,344,012	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	16,017,442	0	16,017,442	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	2,418,019	0	2,418,019	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	3,964,704	0	3,964,704	65.00
65.01	06501	SLEEP LAB	0	0	649,299	0	649,299	65.01
66.00	06600	PHYSICAL THERAPY	0	0	3,346,401	0	3,346,401	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	3,315,023	0	3,315,023	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	43,695	2,945,222	0	2,945,222	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	513,451	0	513,451	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	22,025,082	0	22,025,082	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	29,767,608	0	29,767,608	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	27,248,788	0	27,248,788	73.00
74.00	07400	RENAL DIALYSIS	0	0	1,321,167	0	1,321,167	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	6,155	0	3,557,021	0	3,557,021	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	32,536	998,630	22,894,356	0	22,894,356	91.00
91.01	09101	OP MENTAL HEALTH	0	0	616,660	0	616,660	91.01
91.02	09102	DIABETES CENTER	0	0	425,882	0	425,882	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	5,353,930	0	5,353,930	101.00
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	495,249	1,091,680	353,576,376	0	353,576,376	118.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0213

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part I
Date/Time Prepared:
2/26/2020 4:51 am

Cost Center Description			SOCIAL SERVICE	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	23.00	24.00	25.00	26.00	
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	217,806	0	217,806	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	495,249	1,091,680	353,794,182	0	353,794,182	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0213

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part II
Date/Time Prepared:
2/26/2020 4:51 am

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	88,405	63	88,468	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	5,483,705	9,187,144	14,670,849	5.00
7.00	00700	OPERATION OF PLANT	0	293,545	116,448	409,993	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	100,972	0	100,972	8.00
9.00	00900	HOUSEKEEPING	0	250,328	14,649	264,977	9.00
10.00	01000	DIETARY	0	994,875	4,447	999,322	10.00
11.00	01100	CAFETERIA	0	0	15,207	15,207	11.00
13.00	01300	NURSING ADMINISTRATION	0	125,930	74,808	200,738	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	802,784	223,473	1,026,257	14.00
15.00	01500	PHARMACY	0	331,377	289,425	620,802	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	46,895	1,619	48,514	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
23.00	02300	PARAMED ED PRGM	0	36,693	21,804	58,497	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	5,159,769	260,993	5,420,762	30.00
31.00	03100	INTENSIVE CARE UNIT	0	743,409	264,108	1,007,517	31.00
40.00	04000	SUBPROVIDER - IPF	0	485,112	9,291	494,403	40.00
41.00	04100	SUBPROVIDER - IRF	0	883,088	23,319	906,407	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	42.00
43.00	04300	NURSERY	0	1,993,385	100,586	2,093,971	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	2,403,884	2,995,073	5,398,957	50.00
51.00	05100	RECOVERY ROOM	0	189,902	1,604	191,506	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	186,827	186,827	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,073,385	1,165,159	2,238,544	54.00
54.01	05401	ULTRASOUND	0	131,447	85,769	217,216	54.01
57.00	05700	CT SCAN	0	117,917	333,335	451,252	57.00
58.00	05800	MRI	0	152,027	133,460	285,487	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	26,228	135,837	162,065	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	12,550	12,550	63.00
65.00	06500	RESPIRATORY THERAPY	0	86,041	52,509	138,550	65.00
65.01	06501	SLEEP LAB	0	0	1,807	1,807	65.01
66.00	06600	PHYSICAL THERAPY	0	10,903	5,136	16,039	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	30,103	30,103	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	63,753	163,485	227,238	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	45,538	22,206	67,744	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	126,806	17,061	143,867	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	2,121	2,121	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	1,396,399	257,713	1,654,112	91.00
91.01	09101	OP MENTAL HEALTH	0	134,294	0	134,294	91.01
91.02	09102	DIABETES CENTER	0	0	265	265	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	94.00
99.00	09900	CMHC	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	1,190	1,190	101.00
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	23,778,796	16,210,594	39,989,390	118.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0213

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part II
Date/Time Prepared:
2/26/2020 4:51 am

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
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	79,210	0	79,210	10 190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0 192.00
200.00		Cross Foot Adjustments				0	0 200.00
201.00		Negative Cost Centers		0	0	0	0 201.00
202.00		TOTAL (sum lines 118 through 201)	0	23,858,006	16,210,594	40,068,600	88,468 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0213

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part II
Date/Time Prepared:
2/26/2020 4:51 am

Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	14,683,229					5.00
7.00	00700	OPERATION OF PLANT	597,778	1,010,067				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	17,026	5,668	123,712			8.00
9.00	00900	HOUSEKEEPING	256,995	14,053	0	537,657		9.00
10.00	01000	DIETARY	117,108	55,851	0	30,321	1,202,955	10.00
11.00	01100	CAFETERIA	103,943	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	216,168	7,070	0	3,838	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	132,905	45,067	16	24,467	0	14.00
15.00	01500	PHARMACY	427,593	18,603	0	10,100	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	224,044	2,633	0	1,429	0	16.00
17.00	01700	SOCIAL SERVICE	20,554	0	0	0	0	17.00
23.00	02300	PARAMED ED PRGM	39,368	2,060	2,998	1,118	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	2,383,802	289,663	49,573	157,259	733,742	30.00
31.00	03100	INTENSIVE CARE UNIT	580,618	41,734	8,467	22,657	239,548	31.00
40.00	04000	SUBPROVIDER - IPF	92,548	27,234	391	14,785	25,187	40.00
41.00	04100	SUBPROVIDER - IRF	330,605	49,575	1,903	26,914	204,478	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	266,547	111,906	0	60,754	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,692,261	134,951	20,966	73,265	0	50.00
51.00	05100	RECOVERY ROOM	110,765	10,661	4,201	5,788	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	318,713	0	6,570	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,128,534	60,258	5,975	32,714	0	54.00
54.01	05401	ULTRASOUND	110,921	7,379	926	4,006	0	54.01
57.00	05700	CT SCAN	165,354	6,620	926	3,594	0	57.00
58.00	05800	MRI	88,802	8,535	1,434	4,633	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	635,953	1,472	0	799	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	99,159	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	156,737	4,830	0	2,622	0	65.00
65.01	06501	SLEEP LAB	26,391	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	115,859	612	0	332	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	135,435	0	1,568	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	115,693	3,579	103	1,943	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	14,004	2,556	0	1,388	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	831,777	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,235,428	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	687,236	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	46,327	7,119	0	3,865	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	145,431	0	50	0	0	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	761,914	78,392	17,645	42,559	0	91.00
91.01	09101	OP MENTAL HEALTH	18,867	7,539	0	4,093	0	91.01
91.02	09102	DIABETES CENTER	15,916	0	0	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	213,009	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	14,678,088	1,005,620	123,712	535,243	1,202,955	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	5,141	4,447	0	2,414	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0213

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part II
Date/Time Prepared:
2/26/2020 4:51 am

Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	14,683,229	1,010,067	123,712	537,657	1,202,955	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0213

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part II
Date/Time Prepared:
2/26/2020 4:51 am

Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	120,358					11.00
13.00	01300	NURSING ADMINISTRATION	2,987	432,858				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,602	0	1,232,789			14.00
15.00	01500	PHARMACY	3,338	0	12,274	1,095,287		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,129	0	493	0	283,169	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
23.00	02300	PARAMED ED PRGM	527	0	6,076	5,763	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	31,013	241,462	93,761	329	112,063	30.00
31.00	03100	INTENSIVE CARE UNIT	6,852	53,530	35,465	2,216	34,495	31.00
40.00	04000	SUBPROVIDER - IPF	879	0	408	0	9,002	40.00
41.00	04100	SUBPROVIDER - IRF	4,393	34,484	5,994	0	8,755	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	10,367	81,006	8,424	0	12,102	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	11,860	0	152,033	0	0	50.00
51.00	05100	RECOVERY ROOM	1,230	0	1,497	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	13,602	97	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,752	0	64,374	1,894	0	54.00
54.01	05401	ULTRASOUND	1,318	0	5,186	0	0	54.01
57.00	05700	CT SCAN	1,493	0	12,031	0	0	57.00
58.00	05800	MRI	703	0	2,112	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	5,798	0	158,968	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	351	0	6,287	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	2,548	0	10,261	0	0	65.00
65.01	06501	SLEEP LAB	439	0	1,251	0	0	65.01
66.00	06600	PHYSICAL THERAPY	1,493	0	289	0	26,067	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,933	0	1,547	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,669	0	1,356	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	176	0	278	0	6,055	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	580,675	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	1,084,157	0	73.00
74.00	07400	RENAL DIALYSIS	351	2,880	4,128	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	615	0	3,327	0	1,143	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	9,839	0	46,892	831	73,487	91.00
91.01	09101	OP MENTAL HEALTH	264	0	116	0	0	91.01
91.02	09102	DIABETES CENTER	351	2,770	123	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	16,726	3,561	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	120,270	432,858	1,232,789	1,095,287	283,169	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	88	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0213

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part II
Date/Time Prepared:
2/26/2020 4:51 am

Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	120,358	432,858	1,232,789	1,095,287	283,169	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0213

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part II
Date/Time Prepared:
2/26/2020 4:51 am

Cost Center Description			SOCIAL SERVICE	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	23.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	20,761					17.00
23.00	02300	PARAMED ED PRGM	0	116,685				23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	18,033		9,550,831	0	9,550,831	30.00
31.00	03100	INTENSIVE CARE UNIT	1,106		2,038,744	0	2,038,744	31.00
40.00	04000	SUBPROVIDER - IPF	0		665,303	0	665,303	40.00
41.00	04100	SUBPROVIDER - IRF	0		1,576,040	0	1,576,040	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	42.00
43.00	04300	NURSERY	0		2,646,243	0	2,646,243	43.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
45.00	04500	NURSING FACILITY	0		0	0	0	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0		7,491,956	0	7,491,956	50.00
51.00	05100	RECOVERY ROOM	0		326,609	0	326,609	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		528,610	0	528,610	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		3,547,800	0	3,547,800	54.00
54.01	05401	ULTRASOUND	0		347,789	0	347,789	54.01
57.00	05700	CT SCAN	0		642,147	0	642,147	57.00
58.00	05800	MRI	0		392,194	0	392,194	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	0		967,830	0	967,830	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0		118,547	0	118,547	63.00
65.00	06500	RESPIRATORY THERAPY	0		316,851	0	316,851	65.00
65.01	06501	SLEEP LAB	0		30,056	0	30,056	65.01
66.00	06600	PHYSICAL THERAPY	0		161,650	0	161,650	66.00
67.00	06700	OCCUPATIONAL THERAPY	0		171,734	0	171,734	67.00
68.00	06800	SPEECH PATHOLOGY	0		0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0		352,526	0	352,526	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		92,288	0	92,288	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		1,412,452	0	1,412,452	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		1,235,428	0	1,235,428	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		1,771,393	0	1,771,393	73.00
74.00	07400	RENAL DIALYSIS	0		208,836	0	208,836	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000	CLINIC	258		153,386	0	153,386	90.00
90.01	09001	HOMER GLEN LAB	0		0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0		0	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0		0	0	0	90.03
91.00	09100	EMERGENCY	1,364		2,692,523	0	2,692,523	91.00
91.01	09101	OP MENTAL HEALTH	0		165,291	0	165,291	91.01
91.02	09102	DIABETES CENTER	0		19,581	0	19,581	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0		0	0	0	94.00
99.00	09900	CMHC	0		0	0	0	99.00
99.10	09910	CORF	0		0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0		235,967	0	235,967	101.00
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0		0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0		0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0		0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	20,761	0	39,860,605	0	39,860,605	118.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0213

Period:
From 10/01/2018
To 09/30/2019Worksheet B
Part II
Date/Time Prepared:
2/26/2020 4:51 am

Cost Center Description			SOCIAL SERVICE	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	23.00	24.00	25.00	26.00	
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		91,310	0	91,310	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		0	0	0	192.00
200.00		Cross Foot Adjustments		116,685	116,685	0	116,685	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	20,761	116,685	40,068,600	0	40,068,600	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0213

Period:
From 10/01/2018
To 09/30/2019

Worksheet B-1

Date/Time Prepared:
2/26/2020 4:51 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT	544,870					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		16,245,075				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,019	63	133,351,712			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	125,237	9,206,684	18,672,731	-72,450,649	281,343,533	5.00
7.00	00700	OPERATION OF PLANT	6,704	116,696	3,462,834	0	11,453,871	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,306	0	68,748	0	326,237	8.00
9.00	00900	HOUSEKEEPING	5,717	14,680	2,461,663	0	4,924,210	9.00
10.00	01000	DIETARY	22,721	4,456	532,632	0	2,243,879	10.00
11.00	01100	CAFETERIA	0	15,239	1,821,435	0	1,991,622	11.00
13.00	01300	NURSING ADMINISTRATION	2,876	74,967	3,101,868	0	4,141,942	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	18,334	223,948	716,626	0	2,546,563	14.00
15.00	01500	PHARMACY	7,568	290,041	3,886,131	0	8,192,997	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,071	1,622	2,906,855	0	4,292,862	16.00
17.00	01700	SOCIAL SERVICE	0	0	312,306	0	393,831	17.00
23.00	02300	PARAMED ED PRGM	838	21,850	419,574	0	754,314	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	117,839	261,548	29,132,220	0	45,677,225	30.00
31.00	03100	INTENSIVE CARE UNIT	16,978	264,670	6,846,372	0	11,125,074	31.00
40.00	04000	SUBPROVIDER - IPF	11,079	9,311	702,342	0	1,773,282	40.00
41.00	04100	SUBPROVIDER - IRF	20,168	23,369	3,819,006	0	6,334,640	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	45,525	100,800	1,758,069	0	5,107,235	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	54,900	3,001,445	11,558,245	0	32,425,005	50.00
51.00	05100	RECOVERY ROOM	4,337	1,607	1,450,114	0	2,122,342	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	187,224	4,225,288	0	6,106,780	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	24,514	1,167,638	8,680,917	0	21,623,577	54.00
54.01	05401	ULTRASOUND	3,002	85,951	1,261,719	0	2,125,331	54.01
57.00	05700	CT SCAN	2,693	334,044	1,322,465	0	3,168,312	57.00
58.00	05800	MRI	3,472	133,744	735,816	0	1,701,518	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	599	136,126	4,185,304	0	12,185,350	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	12,577	302,141	0	1,899,960	63.00
65.00	06500	RESPIRATORY THERAPY	1,965	52,621	1,964,943	0	3,003,205	65.00
65.01	06501	SLEEP LAB	0	1,811	252,663	0	505,666	65.01
66.00	06600	PHYSICAL THERAPY	249	5,147	1,446,483	0	2,219,947	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	30,167	1,732,051	0	2,595,032	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,456	163,833	1,425,141	0	2,216,759	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,040	22,253	131,110	0	268,324	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	15,937,483	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	23,671,734	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	13,167,965	73.00
74.00	07400	RENAL DIALYSIS	2,896	17,097	451,463	0	887,657	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	2,126	665,632	0	2,786,566	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	31,891	258,261	8,277,462	0	14,598,856	91.00
91.01	09101	OP MENTAL HEALTH	3,067	0	177,359	0	361,512	91.01
91.02	09102	DIABETES CENTER	0	266	235,040	0	304,956	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	1,193	2,233,648	0	4,081,413	101.00
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0213

Period:
From 10/01/2018
To 09/30/2019

Worksheet B-1

Date/Time Prepared:
2/26/2020 4:51 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5A	5.00	
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	543,061	16,245,075	133,336,416	-72,450,649	281,245,034	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,809	0	15,296	0	98,499	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	23,858,006	16,210,594	34,810,284		72,450,649	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	43.786602	0.997877	0.261041		0.257517	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			88,468		14,683,229	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000663		0.052190	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0213

Period:
From 10/01/2018
To 09/30/2019

Worksheet B-1

Date/Time Prepared:
2/26/2020 4:51 am

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (NUMBER HOUSED)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	410,910				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,306	2,502,943			8.00
9.00	00900	HOUSEKEEPING	5,717	0	402,887		9.00
10.00	01000	DIETARY	22,721	0	22,721	263,979	10.00
11.00	01100	CAFETERIA	0	0	0	1,370	11.00
13.00	01300	NURSING ADMINISTRATION	2,876	0	2,876	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	18,334	319	18,334	0	14.00
15.00	01500	PHARMACY	7,568	0	7,568	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,071	0	1,071	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
23.00	02300	PARAMED ED PRGM	838	60,648	838	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	117,839	1,002,966	117,839	161,014	30.00
31.00	03100	INTENSIVE CARE UNIT	16,978	171,313	16,978	52,567	31.00
40.00	04000	SUBPROVIDER - IPF	11,079	7,912	11,079	5,527	40.00
41.00	04100	SUBPROVIDER - IRF	20,168	38,509	20,168	44,871	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	42.00
43.00	04300	NURSERY	45,525	0	45,525	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	54,900	424,191	54,900	0	50.00
51.00	05100	RECOVERY ROOM	4,337	84,994	4,337	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	132,916	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	24,514	120,876	24,514	0	54.00
54.01	05401	ULTRASOUND	3,002	18,736	3,002	0	54.01
57.00	05700	CT SCAN	2,693	18,736	2,693	0	57.00
58.00	05800	MRI	3,472	29,007	3,472	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	599	0	599	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	1,965	0	1,965	0	65.00
65.01	06501	SLEEP LAB	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	249	0	249	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	31,727	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,456	2,093	1,456	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,040	0	1,040	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	2,896	0	2,896	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	0	1,003	0	0	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0	0	90.03
91.00	09100	EMERGENCY	31,891	356,997	31,891	0	91.00
91.01	09101	OP MENTAL HEALTH	3,067	0	3,067	0	91.01
91.02	09102	DIABETES CENTER	0	0	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	94.00
99.00	09900	CMHC	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	409,101	2,502,943	401,078	263,979	1,369
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,809	0	1,809	0	190.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0213

Period:
From 10/01/2018
To 09/30/2019

Worksheet B-1

Date/Time Prepared:
2/26/2020 4:51 am

Cost Center Description			OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (NUMBER HOUSED)	
			7.00	8.00	9.00	10.00	11.00	
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	14,403,437	491,080	6,392,673	3,978,663	2,504,499	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	35.052535	0.196201	15.867161	15.071892	1,828.101460	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	1,010,067	123,712	537,657	1,202,955	120,358	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.458122	0.049427	1.334511	4.557010	87.852555	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0213

Period:
From 10/01/2018
To 09/30/2019

Worksheet B-1

Date/Time Prepared:
2/26/2020 4:51 am

Cost Center Description			NURSING ADMINISTRATION (DIRECT NRS ING)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	
			13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	1,316,200					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	33,836,049				14.00
15.00	01500	PHARMACY	0	336,887	13,303,144			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	13,531	0	38,911		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	2,816	17.00
23.00	02300	PARAMED ED PRGM	0	166,781	69,995	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	734,217	2,573,439	3,990	15,399	2,446	30.00
31.00	03100	INTENSIVE CARE UNIT	162,770	973,417	26,916	4,740	150	31.00
40.00	04000	SUBPROVIDER - IPF	0	11,188	0	1,237	0	40.00
41.00	04100	SUBPROVIDER - IRF	104,857	164,509	0	1,203	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	246,318	231,222	0	1,663	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	4,172,839	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	41,092	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	373,342	1,176	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,766,862	23,009	0	0	54.00
54.01	05401	ULTRASOUND	0	142,343	0	0	0	54.01
57.00	05700	CT SCAN	0	330,219	0	0	0	57.00
58.00	05800	MRI	0	57,971	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	4,363,179	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	172,558	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	281,643	0	0	0	65.00
65.01	06501	SLEEP LAB	0	34,342	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	7,931	0	3,582	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	42,448	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	37,214	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	7,626	0	832	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	15,937,483	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	13,167,965	0	0	73.00
74.00	07400	RENAL DIALYSIS	8,758	113,310	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	91,304	0	157	35	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	1,287,051	10,093	10,098	185	91.00
91.01	09101	OP MENTAL HEALTH	0	3,197	0	0	0	91.01
91.02	09102	DIABETES CENTER	8,422	3,374	0	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	50,858	97,747	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,316,200	33,836,049	13,303,144	38,911	2,816	118.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0213

Period:
From 10/01/2018
To 09/30/2019

Worksheet B-1

Date/Time Prepared:
2/26/2020 4:51 am

Cost Center Description			NURSING ADMINISTRATION (DIRECT NRS ING)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	
			13.00	14.00	15.00	16.00	17.00	
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	5,417,162	4,210,923	10,799,588	5,540,487	495,249	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	4.115759	0.124451	0.811807	142.388708	175.869673	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	432,858	1,232,789	1,095,287	283,169	20,761	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.328869	0.036434	0.082333	7.277351	7.372514	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0213

Period:
From 10/01/2018
To 09/30/2019Worksheet B-1
Date/Time Prepared:
2/26/2020 4:51 am

Cost Center Description		PARAMED ED PRGM (ASSIGNED TIME)	
		23.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
23.00	02300	PARAMED ED PRGM	23.00
		10,993	
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
40.00	04000	SUBPROVIDER - IPF	40.00
41.00	04100	SUBPROVIDER - IRF	41.00
42.00	04200	SUBPROVIDER	42.00
43.00	04300	NURSERY	43.00
44.00	04400	SKILLED NURSING FACILITY	44.00
45.00	04500	NURSING FACILITY	45.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
51.00	05100	RECOVERY ROOM	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
54.01	05401	ULTRASOUND	54.01
57.00	05700	CT SCAN	57.00
58.00	05800	MRI	58.00
59.00	05900	CARDIAC CATHETERIZATION	59.00
60.00	06000	LABORATORY	60.00
60.01	06001	BLOOD LABORATORY	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	63.00
65.00	06500	RESPIRATORY THERAPY	65.00
65.01	06501	SLEEP LAB	65.01
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
74.00	07400	RENAL DIALYSIS	74.00
OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	89.00
90.00	09000	CLINIC	90.00
90.01	09001	HOMER GLEN LAB	90.01
90.02	09002	HOMER GLEN FEC	90.02
90.03	09003	WOMEN'S HEALTH	90.03
91.00	09100	EMERGENCY	91.00
91.01	09101	OP MENTAL HEALTH	91.01
91.02	09102	DIABETES CENTER	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
OTHER REIMBURSABLE COST CENTERS			
94.00	09400	HOME PROGRAM DIALYSIS	94.00
99.00	09900	CMHC	99.00
99.10	09910	CORF	99.10
101.00	10100	HOME HEALTH AGENCY	101.00
SPECIAL PURPOSE COST CENTERS			
109.00	10900	PANCREAS ACQUISITION	109.00
110.00	11000	INTESTINAL ACQUISITION	110.00
111.00	11100	ISLET ACQUISITION	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEN	190.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0213

Period:
From 10/01/2018
To 09/30/2019

Worksheet B-1

Date/Time Prepared:
2/26/2020 4:51 am

Cost Center Description			PARAMED ED PRGM (ASSIGNED TIME)	
			23.00	
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	192.00
200.00		Cross Foot Adjustments		200.00
201.00		Negative Cost Centers		201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,091,680	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	99.306832	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	116,685	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	10.614482	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)	0	206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)	0.000000	207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0213

Period:
From 10/01/2018
To 09/30/2019Worksheet C
Part I
Date/Time Prepared:
2/26/2020 4:51 am

			Title XVIII		Hospital		PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
					Total Costs	RCE		Total Costs
						Disallowance		
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	72,677,194		72,677,194	139,191	72,816,385	30.00
31.00	03100	INTENSIVE CARE UNIT	17,337,191		17,337,191	28,143	17,365,334	31.00
40.00	04000	SUBPROVIDER - IPF	3,074,733		3,074,733	0	3,074,733	40.00
41.00	04100	SUBPROVIDER - IRF	10,391,451		10,391,451	0	10,391,451	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	42.00
43.00	04300	NURSERY	10,235,625		10,235,625	0	10,235,625	43.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
45.00	04500	NURSING FACILITY	0		0	0	0	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	44,419,821		44,419,821	0	44,419,821	50.00
51.00	05100	RECOVERY ROOM	2,937,103		2,937,103	0	2,937,103	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,802,231		7,802,231	0	7,802,231	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	28,905,464		28,905,464	25,769	28,931,233	54.00
54.01	05401	ULTRASOUND	2,874,314		2,874,314	0	2,874,314	54.01
57.00	05700	CT SCAN	4,197,182		4,197,182	0	4,197,182	57.00
58.00	05800	MRI	2,344,012		2,344,012	0	2,344,012	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	16,017,442		16,017,442	9,781	16,027,223	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,418,019		2,418,019	0	2,418,019	63.00
65.00	06500	RESPIRATORY THERAPY	3,964,704	0	3,964,704	6,337	3,971,041	65.00
65.01	06501	SLEEP LAB	649,299	0	649,299	0	649,299	65.01
66.00	06600	PHYSICAL THERAPY	3,346,401	0	3,346,401	0	3,346,401	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,315,023	0	3,315,023	0	3,315,023	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,945,222		2,945,222	8,243	2,953,465	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	513,451		513,451	561,177	1,074,628	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	22,025,082		22,025,082	0	22,025,082	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	29,767,608		29,767,608	0	29,767,608	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	27,248,788		27,248,788	0	27,248,788	73.00
74.00	07400	RENAL DIALYSIS	1,321,167		1,321,167	4,966	1,326,133	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000	CLINIC	3,557,021		3,557,021	861	3,557,882	90.00
90.01	09001	HOMER GLEN LAB	0		0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0		0	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0		0	0	0	90.03
91.00	09100	EMERGENCY	22,894,356		22,894,356	33,155	22,927,511	91.00
91.01	09101	OP MENTAL HEALTH	616,660		616,660	0	616,660	91.01
91.02	09102	DIABETES CENTER	425,882		425,882	0	425,882	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	11,608,550		11,608,550	0	11,608,550	92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0		0	0	0	94.00
99.00	09900	CMHC	0		0	0	0	99.00
99.10	09910	CORF	0		0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	5,353,930		5,353,930	0	5,353,930	101.00
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0		0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0		0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0		0	0	0	111.00
200.00		Subtotal (see instructions)	365,184,926	0	365,184,926	817,623	366,002,549	200.00
201.00		Less Observation Beds	11,608,550		11,608,550	0	11,608,550	201.00
202.00		Total (see instructions)	353,576,376	0	353,576,376	817,623	354,393,999	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0213

Period:
From 10/01/2018
To 09/30/2019Worksheet C
Part I
Date/Time Prepared:
2/26/2020 4:51 am

			Title XVIII		Hospital	PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	66,227,040		66,227,040		30.00
31.00	03100	INTENSIVE CARE UNIT	21,621,553		21,621,553		31.00
40.00	04000	SUBPROVIDER - IPF	2,273,221		2,273,221		40.00
41.00	04100	SUBPROVIDER - IRF	18,456,014		18,456,014		41.00
42.00	04200	SUBPROVIDER	0		0		42.00
43.00	04300	NURSERY	10,383,947		10,383,947		43.00
44.00	04400	SKILLED NURSING FACILITY	0		0		44.00
45.00	04500	NURSING FACILITY	0		0		45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	52,380,375	88,117,916	140,498,291	0.316159	50.00
51.00	05100	RECOVERY ROOM	17,755,636	15,289,688	33,045,324	0.088881	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,589,170	1,089,115	9,678,285	0.006158	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	44,846,456	147,600,361	192,446,817	0.150200	54.00
54.01	05401	ULTRASOUND	9,358,734	22,713,717	32,072,451	0.089619	54.01
57.00	05700	CT SCAN	35,187,476	87,125,576	122,313,052	0.034315	57.00
58.00	05800	MRI	10,142,099	24,316,011	34,458,110	0.068025	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	63,888,397	112,292,708	176,181,105	0.090915	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	5,522,842	2,417,795	7,940,637	0.304512	63.00
65.00	06500	RESPIRATORY THERAPY	13,121,522	2,584,515	15,706,037	0.252432	65.00
65.01	06501	SLEEP LAB	0	3,772,651	3,772,651	0.172107	65.01
66.00	06600	PHYSICAL THERAPY	12,773,434	947,124	13,720,558	0.243897	66.00
67.00	06700	OCCUPATIONAL THERAPY	8,671	10,995,042	11,003,713	0.301264	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	13,168,704	11,249,462	24,418,166	0.120616	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	969,017	2,269,092	3,238,109	0.158565	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	43,100,573	38,336,642	81,437,215	0.270455	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	32,041,988	14,857,071	46,899,059	0.634717	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	50,609,217	26,612,037	77,221,254	0.352866	73.00
74.00	07400	RENAL DIALYSIS	4,274,108	360,356	4,634,464	0.285074	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	09000	CLINIC	630	11,805,253	11,805,883	0.301292	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0.000000	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0.000000	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0	0.000000	90.03
91.00	09100	EMERGENCY	35,455,999	93,986,138	129,442,137	0.176869	91.00
91.01	09101	OP MENTAL HEALTH	0	745,130	745,130	0.827587	91.01
91.02	09102	DIABETES CENTER	70,222	438,770	508,992	0.836716	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,143,480	10,694,195	12,837,675	0.904256	92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0.000000	94.00
99.00	09900	CMHC	0	0	0		99.00
99.10	09910	CORF	0	0	0		99.10
101.00	10100	HOME HEALTH AGENCY	0	5,924,947	5,924,947		101.00
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0		109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0		110.00
111.00	11100	ISLET ACQUISITION	0	0	0		111.00
200.00		Subtotal (see instructions)	574,370,525	736,541,312	1,310,911,837		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	574,370,525	736,541,312	1,310,911,837		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0213

Period:
From 10/01/2018
To 09/30/2019Worksheet C
Part I
Date/Time Prepared:
2/26/2020 4:51 am

Cost Center Description			PPS Inpatient Ratio	Title XVIII	Hospital	PPS
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
40.00	04000	SUBPROVIDER - IPF				40.00
41.00	04100	SUBPROVIDER - IRF				41.00
42.00	04200	SUBPROVIDER				42.00
43.00	04300	NURSERY				43.00
44.00	04400	SKILLED NURSING FACILITY				44.00
45.00	04500	NURSING FACILITY				45.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.316159			50.00
51.00	05100	RECOVERY ROOM	0.088881			51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.806158			52.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.150334			54.00
54.01	05401	ULTRASOUND	0.089619			54.01
57.00	05700	CT SCAN	0.034315			57.00
58.00	05800	MRI	0.068025			58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000			59.00
60.00	06000	LABORATORY	0.090970			60.00
60.01	06001	BLOOD LABORATORY	0.000000			60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.304512			63.00
65.00	06500	RESPIRATORY THERAPY	0.252835			65.00
65.01	06501	SLEEP LAB	0.172107			65.01
66.00	06600	PHYSICAL THERAPY	0.243897			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.301264			67.00
68.00	06800	SPEECH PATHOLOGY	0.000000			68.00
69.00	06900	ELECTROCARDIOLOGY	0.120954			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.331869			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.270455			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.634717			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.352866			73.00
74.00	07400	RENAL DIALYSIS	0.286146			74.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC				88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER				89.00
90.00	09000	CLINIC	0.301365			90.00
90.01	09001	HOMER GLEN LAB	0.000000			90.01
90.02	09002	HOMER GLEN FEC	0.000000			90.02
90.03	09003	WOMEN'S HEALTH	0.000000			90.03
91.00	09100	EMERGENCY	0.177126			91.00
91.01	09101	OP MENTAL HEALTH	0.827587			91.01
91.02	09102	DIABETES CENTER	0.836716			91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.904256			92.00
OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0.000000			94.00
99.00	09900	CMHC				99.00
99.10	09910	CORF				99.10
101.00	10100	HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION				109.00
110.00	11000	INTESTINAL ACQUISITION				110.00
111.00	11100	ISLET ACQUISITION				111.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0213

Period:
From 10/01/2018
To 09/30/2019Worksheet C
Part I
Date/Time Prepared:
2/26/2020 4:51 am

			Title XIX		Hospital	PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Disallowance	Total Costs
			1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	72,677,194		72,677,194	139,191	72,816,385
31.00	03100	INTENSIVE CARE UNIT	17,337,191		17,337,191	28,143	17,365,334
40.00	04000	SUBPROVIDER - IPF	3,074,733		3,074,733	0	3,074,733
41.00	04100	SUBPROVIDER - IRF	10,391,451		10,391,451	0	10,391,451
42.00	04200	SUBPROVIDER	0		0	0	0
43.00	04300	NURSERY	10,235,625		10,235,625	0	10,235,625
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0
45.00	04500	NURSING FACILITY	0		0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	44,419,821		44,419,821	0	44,419,821
51.00	05100	RECOVERY ROOM	2,937,103		2,937,103	0	2,937,103
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,802,231		7,802,231	0	7,802,231
53.00	05300	ANESTHESIOLOGY	0		0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	28,905,464		28,905,464	25,769	28,931,233
54.01	05401	ULTRASOUND	2,874,314		2,874,314	0	2,874,314
57.00	05700	CT SCAN	4,197,182		4,197,182	0	4,197,182
58.00	05800	MRI	2,344,012		2,344,012	0	2,344,012
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0
60.00	06000	LABORATORY	16,017,442		16,017,442	9,781	16,027,223
60.01	06001	BLOOD LABORATORY	0		0	0	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,418,019		2,418,019	0	2,418,019
65.00	06500	RESPIRATORY THERAPY	3,964,704	0	3,964,704	6,337	3,971,041
65.01	06501	SLEEP LAB	649,299	0	649,299	0	649,299
66.00	06600	PHYSICAL THERAPY	3,346,401	0	3,346,401	0	3,346,401
67.00	06700	OCCUPATIONAL THERAPY	3,315,023	0	3,315,023	0	3,315,023
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	2,945,222		2,945,222	8,243	2,953,465
70.00	07000	ELECTROENCEPHALOGRAPHY	513,451		513,451	561,177	1,074,628
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	22,025,082		22,025,082	0	22,025,082
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	29,767,608		29,767,608	0	29,767,608
73.00	07300	DRUGS CHARGED TO PATIENTS	27,248,788		27,248,788	0	27,248,788
74.00	07400	RENAL DIALYSIS	1,321,167		1,321,167	4,966	1,326,133
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0
90.00	09000	CLINIC	3,557,021		3,557,021	861	3,557,882
90.01	09001	HOMER GLEN LAB	0		0	0	0
90.02	09002	HOMER GLEN FEC	0		0	0	0
90.03	09003	WOMEN'S HEALTH	0		0	0	0
91.00	09100	EMERGENCY	22,894,356		22,894,356	33,155	22,927,511
91.01	09101	OP MENTAL HEALTH	616,660		616,660	0	616,660
91.02	09102	DIABETES CENTER	425,882		425,882	0	425,882
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	11,608,550		11,608,550		11,608,550
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	HOME PROGRAM DIALYSIS	0		0	0	0
99.00	09900	CMHC	0		0	0	0
99.10	09910	CORF	0		0	0	0
101.00	10100	HOME HEALTH AGENCY	5,353,930		5,353,930		5,353,930
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0		0	0	0
110.00	11000	INTESTINAL ACQUISITION	0		0	0	0
111.00	11100	ISLET ACQUISITION	0		0	0	0
200.00		Subtotal (see instructions)	365,184,926	0	365,184,926	817,623	366,002,549
201.00		Less Observation Beds	11,608,550		11,608,550		11,608,550
202.00		Total (see instructions)	353,576,376	0	353,576,376	817,623	354,393,999

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0213

Period:
From 10/01/2018
To 09/30/2019Worksheet C
Part I
Date/Time Prepared:
2/26/2020 4:51 am

			Title XIX		Hospital	PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	66,227,040		66,227,040		30.00
31.00	03100	INTENSIVE CARE UNIT	21,621,553		21,621,553		31.00
40.00	04000	SUBPROVIDER - IPF	2,273,221		2,273,221		40.00
41.00	04100	SUBPROVIDER - IRF	18,456,014		18,456,014		41.00
42.00	04200	SUBPROVIDER	0		0		42.00
43.00	04300	NURSERY	10,383,947		10,383,947		43.00
44.00	04400	SKILLED NURSING FACILITY	0		0		44.00
45.00	04500	NURSING FACILITY	0		0		45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	52,380,375	88,117,916	140,498,291	0.316159	50.00
51.00	05100	RECOVERY ROOM	17,755,636	15,289,688	33,045,324	0.088881	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,589,170	1,089,115	9,678,285	0.006158	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	44,846,456	147,600,361	192,446,817	0.150200	54.00
54.01	05401	ULTRASOUND	9,358,734	22,713,717	32,072,451	0.089619	54.01
57.00	05700	CT SCAN	35,187,476	87,125,576	122,313,052	0.034315	57.00
58.00	05800	MRI	10,142,099	24,316,011	34,458,110	0.068025	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	63,888,397	112,292,708	176,181,105	0.090915	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	5,522,842	2,417,795	7,940,637	0.304512	63.00
65.00	06500	RESPIRATORY THERAPY	13,121,522	2,584,515	15,706,037	0.252432	65.00
65.01	06501	SLEEP LAB	0	3,772,651	3,772,651	0.172107	65.01
66.00	06600	PHYSICAL THERAPY	12,773,434	947,124	13,720,558	0.243897	66.00
67.00	06700	OCCUPATIONAL THERAPY	8,671	10,995,042	11,003,713	0.301264	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	13,168,704	11,249,462	24,418,166	0.120616	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	969,017	2,269,092	3,238,109	0.158565	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	43,100,573	38,336,642	81,437,215	0.270455	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	32,041,988	14,857,071	46,899,059	0.634717	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	50,609,217	26,612,037	77,221,254	0.352866	73.00
74.00	07400	RENAL DIALYSIS	4,274,108	360,356	4,634,464	0.285074	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	89.00
90.00	09000	CLINIC	630	11,805,253	11,805,883	0.301292	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0.000000	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0.000000	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0	0.000000	90.03
91.00	09100	EMERGENCY	35,455,999	93,986,138	129,442,137	0.176869	91.00
91.01	09101	OP MENTAL HEALTH	0	745,130	745,130	0.827587	91.01
91.02	09102	DIABETES CENTER	70,222	438,770	508,992	0.836716	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,143,480	10,694,195	12,837,675	0.904256	92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0.000000	94.00
99.00	09900	CMHC	0	0	0		99.00
99.10	09910	CORF	0	0	0		99.10
101.00	10100	HOME HEALTH AGENCY	0	5,924,947	5,924,947		101.00
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0		109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0		110.00
111.00	11100	ISLET ACQUISITION	0	0	0		111.00
200.00		Subtotal (see instructions)	574,370,525	736,541,312	1,310,911,837		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	574,370,525	736,541,312	1,310,911,837		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0213

Period:
From 10/01/2018
To 09/30/2019Worksheet C
Part I
Date/Time Prepared:
2/26/2020 4:51 am

Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	PPS
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
40.00	04000	SUBPROVIDER - IPF				40.00
41.00	04100	SUBPROVIDER - IRF				41.00
42.00	04200	SUBPROVIDER				42.00
43.00	04300	NURSERY				43.00
44.00	04400	SKILLED NURSING FACILITY				44.00
45.00	04500	NURSING FACILITY				45.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.316159			50.00
51.00	05100	RECOVERY ROOM	0.088881			51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.806158			52.00
53.00	05300	ANESTHESIOLOGY	0.000000			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.150334			54.00
54.01	05401	ULTRASOUND	0.089619			54.01
57.00	05700	CT SCAN	0.034315			57.00
58.00	05800	MRI	0.068025			58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000			59.00
60.00	06000	LABORATORY	0.090970			60.00
60.01	06001	BLOOD LABORATORY	0.000000			60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.304512			63.00
65.00	06500	RESPIRATORY THERAPY	0.252835			65.00
65.01	06501	SLEEP LAB	0.172107			65.01
66.00	06600	PHYSICAL THERAPY	0.243897			66.00
67.00	06700	OCCUPATIONAL THERAPY	0.301264			67.00
68.00	06800	SPEECH PATHOLOGY	0.000000			68.00
69.00	06900	ELECTROCARDIOLOGY	0.120954			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.331869			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.270455			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.634717			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.352866			73.00
74.00	07400	RENAL DIALYSIS	0.286146			74.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000			88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000			89.00
90.00	09000	CLINIC	0.301365			90.00
90.01	09001	HOMER GLEN LAB	0.000000			90.01
90.02	09002	HOMER GLEN FEC	0.000000			90.02
90.03	09003	WOMEN'S HEALTH	0.000000			90.03
91.00	09100	EMERGENCY	0.177126			91.00
91.01	09101	OP MENTAL HEALTH	0.827587			91.01
91.02	09102	DIABETES CENTER	0.836716			91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.904256			92.00
OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0.000000			94.00
99.00	09900	CMHC				99.00
99.10	09910	CORF				99.10
101.00	10100	HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION				109.00
110.00	11000	INTESTINAL ACQUISITION				110.00
111.00	11100	ISLET ACQUISITION				111.00
200.00		Subtotal (see instructions)				200.00
201.00		Less Observation Beds				201.00
202.00		Total (see instructions)				202.00

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

Provider CCN: 14-0213

Period:
From 10/01/2018
To 09/30/2019Worksheet C
Part II
Date/Time Prepared:
2/26/2020 4:51 am

Cost Center Description			Title XIX		Hospital	PPS	
			Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount
			1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	44,419,821	7,491,956	36,927,865	0	0
51.00	05100	RECOVERY ROOM	2,937,103	326,609	2,610,494	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,802,231	528,610	7,273,621	0	0
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	28,905,464	3,547,800	25,357,664	0	0
54.01	05401	ULTRASOUND	2,874,314	347,789	2,526,525	0	0
57.00	05700	CT SCAN	4,197,182	642,147	3,555,035	0	0
58.00	05800	MRI	2,344,012	392,194	1,951,818	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	16,017,442	967,830	15,049,612	0	0
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,418,019	118,547	2,299,472	0	0
65.00	06500	RESPIRATORY THERAPY	3,964,704	316,851	3,647,853	0	0
65.01	06501	SLEEP LAB	649,299	30,056	619,243	0	0
66.00	06600	PHYSICAL THERAPY	3,346,401	161,650	3,184,751	0	0
67.00	06700	OCCUPATIONAL THERAPY	3,315,023	171,734	3,143,289	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	2,945,222	352,526	2,592,696	0	0
70.00	07000	ELECTROENCEPHALOGRAPHY	513,451	92,288	421,163	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	22,025,082	1,412,452	20,612,630	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	29,767,608	1,235,428	28,532,180	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	27,248,788	1,771,393	25,477,395	0	0
74.00	07400	RENAL DIALYSIS	1,321,167	208,836	1,112,331	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00	09000	CLINIC	3,557,021	153,386	3,403,635	0	0
90.01	09001	HOMER GLEN LAB	0	0	0	0	0
90.02	09002	HOMER GLEN FEC	0	0	0	0	0
90.03	09003	WOMEN'S HEALTH	0	0	0	0	0
91.00	09100	EMERGENCY	22,894,356	2,692,523	20,201,833	0	0
91.01	09101	OP MENTAL HEALTH	616,660	165,291	451,369	0	0
91.02	09102	DIABETES CENTER	425,882	19,581	406,301	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	11,608,550	1,522,612	10,085,938	0	0
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0
99.00	09900	CMHC	0	0	0	0	0
99.10	09910	CORF	0	0	0	0	0
101.00	10100	HOME HEALTH AGENCY	5,353,930	235,967	5,117,963	0	0
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0
111.00	11100	ISLET ACQUISITION	0	0	0	0	0
200.00		Subtotal (sum of lines 50 thru 199)	251,468,732	24,906,056	226,562,676	0	0
201.00		Less Observation Beds	11,608,550	1,522,612	10,085,938	0	0
202.00		Total (line 200 minus line 201)	239,860,182	23,383,444	216,476,738	0	0

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

Provider CCN: 14-0213

Period:
From 10/01/2018
To 09/30/2019Worksheet C
Part II
Date/Time Prepared:
2/26/2020 4:51 am

				Title XIX		Hospital	PPS		
Cost Center Description			Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)				
			6.00	7.00	8.00				
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	44,419,821	140,498,291	0.316159			50.00	
51.00	05100	RECOVERY ROOM	2,937,103	33,045,324	0.088881			51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,802,231	9,678,285	0.806158			52.00	
53.00	05300	ANESTHESIOLOGY	0	0	0.000000			53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	28,905,464	192,446,817	0.150200			54.00	
54.01	05401	ULTRASOUND	2,874,314	32,072,451	0.089619			54.01	
57.00	05700	CT SCAN	4,197,182	122,313,052	0.034315			57.00	
58.00	05800	MRI	2,344,012	34,458,110	0.068025			58.00	
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000			59.00	
60.00	06000	LABORATORY	16,017,442	176,181,105	0.090915			60.00	
60.01	06001	BLOOD LABORATORY	0	0	0.000000			60.01	
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,418,019	7,940,637	0.304512			63.00	
65.00	06500	RESPIRATORY THERAPY	3,964,704	15,706,037	0.252432			65.00	
65.01	06501	SLEEP LAB	649,299	3,772,651	0.172107			65.01	
66.00	06600	PHYSICAL THERAPY	3,346,401	13,720,558	0.243897			66.00	
67.00	06700	OCCUPATIONAL THERAPY	3,315,023	11,003,713	0.301264			67.00	
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000			68.00	
69.00	06900	ELECTROCARDIOLOGY	2,945,222	24,418,166	0.120616			69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	513,451	3,238,109	0.158565			70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	22,025,082	81,437,215	0.270455			71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	29,767,608	46,899,059	0.634717			72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	27,248,788	77,221,254	0.352866			73.00	
74.00	07400	RENAL DIALYSIS	1,321,167	4,634,464	0.285074			74.00	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000			88.00	
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000			89.00	
90.00	09000	CLINIC	3,557,021	11,805,883	0.301292			90.00	
90.01	09001	HOMER GLEN LAB	0	0	0.000000			90.01	
90.02	09002	HOMER GLEN FEC	0	0	0.000000			90.02	
90.03	09003	WOMEN'S HEALTH	0	0	0.000000			90.03	
91.00	09100	EMERGENCY	22,894,356	129,442,137	0.176869			91.00	
91.01	09101	OP MENTAL HEALTH	616,660	745,130	0.827587			91.01	
91.02	09102	DIABETES CENTER	425,882	508,992	0.836716			91.02	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	11,608,550	12,837,675	0.904256			92.00	
	OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0.000000			94.00	
99.00	09900	CMHC	0	0	0.000000			99.00	
99.10	09910	CORF	0	0	0.000000			99.10	
101.00	10100	HOME HEALTH AGENCY	5,353,930	5,924,947	0.903625			101.00	
	SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0.000000			109.00	
110.00	11000	INTESTINAL ACQUISITION	0	0	0.000000			110.00	
111.00	11100	ISLET ACQUISITION	0	0	0.000000			111.00	
200.00		Subtotal (sum of lines 50 thru 199)	251,468,732	1,191,950,062				200.00	
201.00		Less Observation Beds	11,608,550	0				201.00	
202.00		Total (line 200 minus line 201)	239,860,182	1,191,950,062				202.00	

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS				Provider CCN: 14-0213	Period: From 10/01/2018 To 09/30/2019	Worksheet D Part I Date/Time Prepared: 2/26/2020 4:51 am	
				Title XVIII	Hospital	PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	9,550,831	0	9,550,831	69,727	136.97	30.00
31.00	INTENSIVE CARE UNIT	2,038,744		2,038,744	8,067	252.73	31.00
40.00	SUBPROVIDER - IPF	665,303	0	665,303	2,016	330.01	40.00
41.00	SUBPROVIDER - IRF	1,576,040	0	1,576,040	7,726	203.99	41.00
42.00	SUBPROVIDER	0	0	0	0	0.00	42.00
43.00	NURSERY	2,646,243		2,646,243	7,557	350.17	43.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
45.00	NURSING FACILITY	0		0	0	0.00	45.00
200.00	Total (lines 30 through 199)	16,477,161		16,477,161	95,093		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	25,420	3,481,777				30.00
31.00	INTENSIVE CARE UNIT	3,370	851,700				31.00
40.00	SUBPROVIDER - IPF	319	105,273				40.00
41.00	SUBPROVIDER - IRF	4,990	1,017,910				41.00
42.00	SUBPROVIDER	0	0				42.00
43.00	NURSERY	0	0				43.00
44.00	SKILLED NURSING FACILITY	0	0				44.00
45.00	NURSING FACILITY	0	0				45.00
200.00	Total (lines 30 through 199)	34,099	5,456,660				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 14-0213	Period: From 10/01/2018 To 09/30/2019	Worksheet D Part II Date/Time Prepared: 2/26/2020 4:51 am		
				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	7,491,956	140,498,291	0.053324	19,401,019	1,034,540	50.00
51.00	05100	RECOVERY ROOM	326,609	33,045,324	0.009884	5,089,512	50,305	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	528,610	9,678,285	0.054618	1,843	101	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,547,800	192,446,817	0.018435	21,026,855	387,630	54.00
54.01	05401	ULTRASOUND	347,789	32,072,451	0.010844	4,283,921	46,455	54.01
57.00	05700	CT SCAN	642,147	122,313,052	0.005250	17,906,783	94,011	57.00
58.00	05800	MRI	392,194	34,458,110	0.011382	4,392,181	49,992	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	967,830	176,181,105	0.005493	27,456,202	150,817	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	118,547	7,940,637	0.014929	2,089,261	31,191	63.00
65.00	06500	RESPIRATORY THERAPY	316,851	15,706,037	0.020174	6,102,407	123,110	65.00
65.01	06501	SLEEP LAB	30,056	3,772,651	0.007967	0	0	65.01
66.00	06600	PHYSICAL THERAPY	161,650	13,720,558	0.011782	4,505,123	53,079	66.00
67.00	06700	OCCUPATIONAL THERAPY	171,734	11,003,713	0.015607	706	11	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	352,526	24,418,166	0.014437	6,674,311	96,357	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	92,288	3,238,109	0.028501	416,869	11,881	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,412,452	81,437,215	0.017344	15,703,793	272,367	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,235,428	46,899,059	0.026342	14,516,698	382,399	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,771,393	77,221,254	0.022939	16,345,157	374,942	73.00
74.00	07400	RENAL DIALYSIS	208,836	4,634,464	0.045062	2,238,424	100,868	74.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	153,386	11,805,883	0.012992	31	0	90.00
90.01	09001	HOMER GLEN LAB	0	0	0.000000	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0.000000	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0.000000	0	0	90.03
91.00	09100	EMERGENCY	2,692,523	129,442,137	0.020801	16,088,372	334,654	91.00
91.01	09101	OP MENTAL HEALTH	165,291	745,130	0.221828	0	0	91.01
91.02	09102	DIABETES CENTER	19,581	508,992	0.038470	16,450	633	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,522,612	12,837,675	0.118605	881,175	104,512	92.00
	OTHER REIMBURSABLE COST CENTERS							
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0.000000	0	0	94.00
200.00		Total (lines 50 through 199)	24,670,089	1,186,025,115		185,137,093	3,699,855	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0213		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part III Date/Time Prepared: 2/26/2020 4:51 am	
					Title XVIII		Hospital		PPS	
Cost Center Description			Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost			
			1A	1.00	2A	2.00	3.00			
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0	31.00	
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	0	40.00	
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	0	41.00	
42.00	04200	SUBPROVIDER	0	0	0	0	0	0	42.00	
43.00	04300	NURSERY	0	0	0	0	0	0	43.00	
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	0	44.00	
45.00	04500	NURSING FACILITY	0	0	0	0	0	0	45.00	
200.00		Total (lines 30 through 199)	0	0	0	0	0	0	200.00	
Cost Center Description			Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days			
			4.00	5.00	6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	69,727	0.00	25,420	30.00		
31.00	03100	INTENSIVE CARE UNIT	0	0	8,067	0.00	3,370	31.00		
40.00	04000	SUBPROVIDER - IPF	0	0	2,016	0.00	319	40.00		
41.00	04100	SUBPROVIDER - IRF	0	0	7,726	0.00	4,990	41.00		
42.00	04200	SUBPROVIDER	0	0	0	0.00	0	42.00		
43.00	04300	NURSERY	0	0	7,557	0.00	0	43.00		
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0.00	0	44.00		
45.00	04500	NURSING FACILITY	0	0	0	0.00	0	45.00		
200.00		Total (lines 30 through 199)	0	0	95,093		34,099	200.00		
Cost Center Description			Inpatient Program Pass-Through Cost (col. 7 x col. 8)							
			9.00							
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	30.00						
31.00	03100	INTENSIVE CARE UNIT	0	31.00						
40.00	04000	SUBPROVIDER - IPF	0	40.00						
41.00	04100	SUBPROVIDER - IRF	0	41.00						
42.00	04200	SUBPROVIDER	0	42.00						
43.00	04300	NURSERY	0	43.00						
44.00	04400	SKILLED NURSING FACILITY	0	44.00						
45.00	04500	NURSING FACILITY	0	45.00						
200.00		Total (lines 30 through 199)	0	200.00						

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0213		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part IV Date/Time Prepared: 2/26/2020 4:51 am	
			Title XVIII		Hospital		PPS	
Cost Center Description			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	49,355	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
65.01	06501	SLEEP LAB	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	43,695	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	0	0	998,630	91.00
91.01	09101	OP MENTAL HEALTH	0	0	0	0	0	91.01
91.02	09102	DIABETES CENTER	0	0	0	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
200.00		Total (lines 50 through 199)	0	0	0	0	1,091,680	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0213

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part IV
Date/Time Prepared:
2/26/2020 4:51 am

				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)	
			4.00	5.00	6.00	7.00	8.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	140,498,291	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	33,045,324	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	49,355	49,355	9,678,285	0.005100	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	192,446,817	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	32,072,451	0.000000	54.01
57.00	05700	CT SCAN	0	0	0	122,313,052	0.000000	57.00
58.00	05800	MRI	0	0	0	34,458,110	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	176,181,105	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	7,940,637	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	15,706,037	0.000000	65.00
65.01	06501	SLEEP LAB	0	0	0	3,772,651	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	13,720,558	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	11,003,713	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	43,695	43,695	24,418,166	0.001789	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	3,238,109	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	81,437,215	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	46,899,059	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	77,221,254	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	4,634,464	0.000000	74.00
	OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000	89.00
90.00	09000	CLINIC	0	0	0	11,805,883	0.000000	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	0.000000	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	0.000000	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0	0	0.000000	90.03
91.00	09100	EMERGENCY	0	998,630	998,630	129,442,137	0.007715	91.00
91.01	09101	OP MENTAL HEALTH	0	0	0	745,130	0.000000	91.01
91.02	09102	DIABETES CENTER	0	0	0	508,992	0.000000	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	12,837,675	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS							
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0.000000	94.00
200.00		Total (lines 50 through 199)	0	1,091,680	1,091,680	1,186,025,115		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0213

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part IV
Date/Time Prepared:
2/26/2020 4:51 am

				Title XVIII		Hospital		PPS	
Cost Center Description			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			9.00	10.00	11.00	12.00	13.00		
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	19,401,019	0	20,930,127	0	50.00	
51.00	05100	RECOVERY ROOM	0.000000	5,089,512	0	2,961,088	0	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.005100	1,843	9	1,555	8	52.00	
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	21,026,855	0	53,519,068	0	54.00	
54.01	05401	ULTRASOUND	0.000000	4,283,921	0	4,022,015	0	54.01	
57.00	05700	CT SCAN	0.000000	17,906,783	0	23,944,259	0	57.00	
58.00	05800	MRI	0.000000	4,392,181	0	10,690,152	0	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00	
60.00	06000	LABORATORY	0.000000	27,456,202	0	11,917,815	0	60.00	
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01	
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	2,089,261	0	580,391	0	63.00	
65.00	06500	RESPIRATORY THERAPY	0.000000	6,102,407	0	533,422	0	65.00	
65.01	06501	SLEEP LAB	0.000000	0	0	901,915	0	65.01	
66.00	06600	PHYSICAL THERAPY	0.000000	4,505,123	0	43,603	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0.000000	706	0	138,873	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	0.001789	6,674,311	11,940	3,279,727	5,867	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	416,869	0	445,440	0	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	15,703,793	0	10,501,847	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	14,516,698	0	4,757,304	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	16,345,157	0	1,367,912	0	73.00	
74.00	07400	RENAL DIALYSIS	0.000000	2,238,424	0	142,728	0	74.00	
	OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00	
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	89.00	
90.00	09000	CLINIC	0.000000	31	0	794,102	0	90.00	
90.01	09001	HOMER GLEN LAB	0.000000	0	0	0	0	90.01	
90.02	09002	HOMER GLEN FEC	0.000000	0	0	0	0	90.02	
90.03	09003	WOMEN'S HEALTH	0.000000	0	0	0	0	90.03	
91.00	09100	EMERGENCY	0.007715	16,088,372	124,122	14,604,581	112,674	91.00	
91.01	09101	OP MENTAL HEALTH	0.000000	0	0	49,253	0	91.01	
91.02	09102	DIABETES CENTER	0.000000	16,450	0	33,269	0	91.02	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	881,175	0	3,082,500	0	92.00	
	OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0.000000	0	0	0	0	94.00	
200.00		Total (lines 50 through 199)		185,137,093	136,071	169,242,946	118,549	200.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST				Provider CCN: 14-0213	Period: From 10/01/2018 To 09/30/2019	Worksheet D Part V Date/Time Prepared: 2/26/2020 4:51 am		
				Title XVIII	Hospital	PPS		
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs	
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.316159	20,930,127	17,239	0	6,617,248	50.00
51.00	05100	RECOVERY ROOM	0.088881	2,961,088	0	0	263,184	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.806158	1,555	0	0	1,254	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.150200	53,519,068	0	0	8,038,564	54.00
54.01	05401	ULTRASOUND	0.089619	4,022,015	0	0	360,449	54.01
57.00	05700	CT SCAN	0.034315	23,944,259	0	0	821,647	57.00
58.00	05800	MRI	0.068025	10,690,152	0	0	727,198	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.090915	11,917,815	0	0	1,083,508	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.304512	580,391	0	0	176,736	63.00
65.00	06500	RESPIRATORY THERAPY	0.252432	533,422	0	0	134,653	65.00
65.01	06501	SLEEP LAB	0.172107	901,915	0	0	155,226	65.01
66.00	06600	PHYSICAL THERAPY	0.243897	43,603	0	0	10,635	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.301264	138,873	0	0	41,837	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.120616	3,279,727	0	0	395,588	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.158565	445,440	0	0	70,631	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.270455	10,501,847	0	0	2,840,277	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.634717	4,757,304	43,099	0	3,019,542	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.352866	1,367,912	0	38,229	482,690	73.00
74.00	07400	RENAL DIALYSIS	0.285074	142,728	0	0	40,688	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
90.00	09000	CLINIC	0.301292	794,102	0	332	239,257	90.00
90.01	09001	HOMER GLEN LAB	0.000000	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0.000000	0	0	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0.000000	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.176869	14,604,581	0	0	2,583,098	91.00
91.01	09101	OP MENTAL HEALTH	0.827587	49,253	0	0	40,761	91.01
91.02	09102	DIABETES CENTER	0.836716	33,269	0	0	27,837	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.904256	3,082,500	0	0	2,787,369	92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0.000000		0			94.00
200.00		Subtotal (see instructions)		169,242,946	60,338	38,561	30,959,877	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		169,242,946	60,338	38,561	30,959,877	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0213

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part V
Date/Time Prepared:
2/26/2020 4:51 am

			Title XVIII		Hospital	PPS
Cost Center Description			Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	5,450	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	05401	ULTRASOUND	0	0		54.01
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
65.01	06501	SLEEP LAB	0	0		65.01
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	27,356	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	13,490		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
	OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	09000	CLINIC	0	100		90.00
90.01	09001	HOMER GLEN LAB	0	0		90.01
90.02	09002	HOMER GLEN FEC	0	0		90.02
90.03	09003	WOMEN'S HEALTH	0	0		90.03
91.00	09100	EMERGENCY	0	0		91.00
91.01	09101	OP MENTAL HEALTH	0	0		91.01
91.02	09102	DIABETES CENTER	0	0		91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
	OTHER REIMBURSABLE COST CENTERS					
94.00	09400	HOME PROGRAM DIALYSIS	0	0		94.00
200.00		Subtotal (see instructions)	32,806	13,590		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	32,806	13,590		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 14-0213 Component CCN: 14-S213	Period: From 10/01/2018 To 09/30/2019	Worksheet D Part II Date/Time Prepared: 2/26/2020 4:51 am	
				Title XVIII		Subprovider - IPF	PPS
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)
			1.00	2.00	3.00	4.00	5.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,491,956	140,498,291	0.053324	500	27
51.00	05100	RECOVERY ROOM	326,609	33,045,324	0.009884	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	528,610	9,678,285	0.054618	0	0
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,547,800	192,446,817	0.018435	2,641	49
54.01	05401	ULTRASOUND	347,789	32,072,451	0.010844	0	0
57.00	05700	CT SCAN	642,147	122,313,052	0.005250	9,082	48
58.00	05800	MRI	392,194	34,458,110	0.011382	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0
60.00	06000	LABORATORY	967,830	176,181,105	0.005493	79,583	437
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	118,547	7,940,637	0.014929	2,016	30
65.00	06500	RESPIRATORY THERAPY	316,851	15,706,037	0.020174	2,790	56
65.01	06501	SLEEP LAB	30,056	3,772,651	0.007967	0	0
66.00	06600	PHYSICAL THERAPY	161,650	13,720,558	0.011782	1,074	13
67.00	06700	OCCUPATIONAL THERAPY	171,734	11,003,713	0.015607	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0
69.00	06900	ELECTROCARDIOLOGY	352,526	24,418,166	0.014437	4,214	61
70.00	07000	ELECTROENCEPHALOGRAPHY	92,288	3,238,109	0.028501	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,412,452	81,437,215	0.017344	1,844	32
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,235,428	46,899,059	0.026342	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	1,771,393	77,221,254	0.022939	7,521	173
74.00	07400	RENAL DIALYSIS	208,836	4,634,464	0.045062	0	0
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0
90.00	09000	CLINIC	153,386	11,805,883	0.012992	0	0
90.01	09001	HOMER GLEN LAB	0	0	0.000000	0	0
90.02	09002	HOMER GLEN FEC	0	0	0.000000	0	0
90.03	09003	WOMEN'S HEALTH	0	0	0.000000	0	0
91.00	09100	EMERGENCY	2,692,523	129,442,137	0.020801	70,993	1,477
91.01	09101	OP MENTAL HEALTH	165,291	745,130	0.221828	0	0
91.02	09102	DIABETES CENTER	19,581	508,992	0.038470	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	12,837,675	0.000000	0	0
	OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0.000000	0	0
200.00		Total (lines 50 through 199)	23,147,477	1,186,025,115		182,258	2,403

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0213 Component CCN: 14-S213		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part IV Date/Time Prepared: 2/26/2020 4:51 am	
			Title XVIII		Subprovider - IPF		PPS	
Cost Center Description			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	49,355	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
65.01	06501	SLEEP LAB	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	43,695	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	0	0	998,630	91.00
91.01	09101	OP MENTAL HEALTH	0	0	0	0	0	91.01
91.02	09102	DIABETES CENTER	0	0	0	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
200.00		Total (lines 50 through 199)	0	0	0	0	1,091,680	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0213 Component CCN: 14-S213		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part IV Date/Time Prepared: 2/26/2020 4:51 am	
			Title XVIII		Subprovider - IPF		PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	140,498,291	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	33,045,324	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	49,355	49,355	9,678,285	0.005100	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	192,446,817	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	32,072,451	0.000000	54.01
57.00	05700	CT SCAN	0	0	0	122,313,052	0.000000	57.00
58.00	05800	MRI	0	0	0	34,458,110	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	176,181,105	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	7,940,637	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	15,706,037	0.000000	65.00
65.01	06501	SLEEP LAB	0	0	0	3,772,651	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	13,720,558	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	11,003,713	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	43,695	43,695	24,418,166	0.001789	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	3,238,109	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	81,437,215	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	46,899,059	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	77,221,254	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	4,634,464	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000	89.00
90.00	09000	CLINIC	0	0	0	11,805,883	0.000000	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	0.000000	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	0.000000	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0	0	0.000000	90.03
91.00	09100	EMERGENCY	0	998,630	998,630	129,442,137	0.007715	91.00
91.01	09101	OP MENTAL HEALTH	0	0	0	745,130	0.000000	91.01
91.02	09102	DIABETES CENTER	0	0	0	508,992	0.000000	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	12,837,675	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0.000000	94.00
200.00		Total (lines 50 through 199)	0	1,091,680	1,091,680	1,186,025,115		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0213 Component CCN: 14-S213		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part IV Date/Time Prepared: 2/26/2020 4:51 am	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			9.00	10.00	11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0.000000	500	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	0.005100	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	2,641	0	0	0	54.00	
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	54.01	
57.00	05700	CT SCAN	0.000000	9,082	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	79,583	0	0	0	60.00	
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01	
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	2,016	0	0	0	63.00	
65.00	06500	RESPIRATORY THERAPY	0.000000	2,790	0	0	0	65.00	
65.01	06501	SLEEP LAB	0.000000	0	0	0	0	65.01	
66.00	06600	PHYSICAL THERAPY	0.000000	1,074	0	0	0	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00	
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	0.001789	4,214	8	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	1,844	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	7,521	0	0	0	73.00	
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00	
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00	
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	89.00	
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00	
90.01	09001	HOMER GLEN LAB	0.000000	0	0	0	0	90.01	
90.02	09002	HOMER GLEN FEC	0.000000	0	0	0	0	90.02	
90.03	09003	WOMEN'S HEALTH	0.000000	0	0	0	0	90.03	
91.00	09100	EMERGENCY	0.007715	70,993	548	0	0	91.00	
91.01	09101	OP MENTAL HEALTH	0.000000	0	0	0	0	91.01	
91.02	09102	DIABETES CENTER	0.000000	0	0	0	0	91.02	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00	
OTHER REIMBURSABLE COST CENTERS									
94.00	09400	HOME PROGRAM DIALYSIS	0.000000	0	0	0	0	94.00	
200.00	Total (lines 50 through 199)			182,258	556	0	0	200.00	

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 14-0213	Period: From 10/01/2018 To 09/30/2019	Worksheet D Part II Date/Time Prepared: 2/26/2020 4:51 am	
				Component CCN: 14-T213			
				Title XVIII		Subprovider - IRF	PPS
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)
			1.00	2.00	3.00	4.00	5.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,491,956	140,498,291	0.053324	7,572	404
51.00	05100	RECOVERY ROOM	326,609	33,045,324	0.009884	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	528,610	9,678,285	0.054618	0	0
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,547,800	192,446,817	0.018435	105,344	1,942
54.01	05401	ULTRASOUND	347,789	32,072,451	0.010844	81,201	881
57.00	05700	CT SCAN	642,147	122,313,052	0.005250	178,812	939
58.00	05800	MRI	392,194	34,458,110	0.011382	82,240	936
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0
60.00	06000	LABORATORY	967,830	176,181,105	0.005493	1,073,334	5,896
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	118,547	7,940,637	0.014929	47,332	707
65.00	06500	RESPIRATORY THERAPY	316,851	15,706,037	0.020174	304,868	6,150
65.01	06501	SLEEP LAB	30,056	3,772,651	0.007967	0	0
66.00	06600	PHYSICAL THERAPY	161,650	13,720,558	0.011782	3,069,270	36,162
67.00	06700	OCCUPATIONAL THERAPY	171,734	11,003,713	0.015607	320	5
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0
69.00	06900	ELECTROCARDIOLOGY	352,526	24,418,166	0.014437	30,427	439
70.00	07000	ELECTROENCEPHALOGRAPHY	92,288	3,238,109	0.028501	11,329	323
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,412,452	81,437,215	0.017344	325,294	5,642
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,235,428	46,899,059	0.026342	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	1,771,393	77,221,254	0.022939	538,949	12,363
74.00	07400	RENAL DIALYSIS	208,836	4,634,464	0.045062	239,069	10,773
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0
90.00	09000	CLINIC	153,386	11,805,883	0.012992	0	0
90.01	09001	HOMER GLEN LAB	0	0	0.000000	0	0
90.02	09002	HOMER GLEN FEC	0	0	0.000000	0	0
90.03	09003	WOMEN'S HEALTH	0	0	0.000000	0	0
91.00	09100	EMERGENCY	2,692,523	129,442,137	0.020801	307	6
91.01	09101	OP MENTAL HEALTH	165,291	745,130	0.221828	0	0
91.02	09102	DIABETES CENTER	19,581	508,992	0.038470	1,213	47
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	12,837,675	0.000000	0	0
	OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0.000000	0	0
200.00		Total (lines 50 through 199)	23,147,477	1,186,025,115		6,096,881	83,615

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0213 Component CCN: 14-T213		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part IV Date/Time Prepared: 2/26/2020 4:51 am	
			Title XVIII		Subprovider - IRF		PPS	
Cost Center Description			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	49,355	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
65.01	06501	SLEEP LAB	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	43,695	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	0	0	998,630	91.00
91.01	09101	OP MENTAL HEALTH	0	0	0	0	0	91.01
91.02	09102	DIABETES CENTER	0	0	0	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
200.00		Total (lines 50 through 199)	0	0	0	0	1,091,680	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0213 Component CCN: 14-T213		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part IV Date/Time Prepared: 2/26/2020 4:51 am	
			Title XVIII		Subprovider - IRF		PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	140,498,291	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	33,045,324	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	49,355	49,355	9,678,285	0.005100	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	192,446,817	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	32,072,451	0.000000	54.01
57.00	05700	CT SCAN	0	0	0	122,313,052	0.000000	57.00
58.00	05800	MRI	0	0	0	34,458,110	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	176,181,105	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	7,940,637	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	15,706,037	0.000000	65.00
65.01	06501	SLEEP LAB	0	0	0	3,772,651	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	13,720,558	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	11,003,713	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	43,695	43,695	24,418,166	0.001789	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	3,238,109	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	81,437,215	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	46,899,059	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	77,221,254	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	4,634,464	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000	89.00
90.00	09000	CLINIC	0	0	0	11,805,883	0.000000	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	0.000000	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	0.000000	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0	0	0.000000	90.03
91.00	09100	EMERGENCY	0	998,630	998,630	129,442,137	0.007715	91.00
91.01	09101	OP MENTAL HEALTH	0	0	0	745,130	0.000000	91.01
91.02	09102	DIABETES CENTER	0	0	0	508,992	0.000000	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	12,837,675	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0.000000	94.00
200.00		Total (lines 50 through 199)	0	1,091,680	1,091,680	1,186,025,115		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0213 Component CCN: 14-T213		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part IV Date/Time Prepared: 2/26/2020 4:51 am	
				Title XVIII		Subprovider - IRF		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0.000000	7,572	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		0.005100	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	105,344	0	0	0	54.00
54.01	05401	ULTRASOUND		0.000000	81,201	0	0	0	54.01
57.00	05700	CT SCAN		0.000000	178,812	0	0	0	57.00
58.00	05800	MRI		0.000000	82,240	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY		0.000000	1,073,334	0	0	0	60.00
60.01	06001	BLOOD LABORATORY		0.000000	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.		0.000000	47,332	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY		0.000000	304,868	0	0	0	65.00
65.01	06501	SLEEP LAB		0.000000	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY		0.000000	3,069,270	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		0.000000	320	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY		0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0.001789	30,427	54	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0.000000	11,329	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.000000	325,294	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	538,949	0	0	0	73.00
74.00	07400	RENAL DIALYSIS		0.000000	239,069	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC		0.000000	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER		0.000000	0	0	0	0	89.00
90.00	09000	CLINIC		0.000000	0	0	0	0	90.00
90.01	09001	HOMER GLEN LAB		0.000000	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC		0.000000	0	0	0	0	90.02
90.03	09003	WOMEN'S HEALTH		0.000000	0	0	0	0	90.03
91.00	09100	EMERGENCY		0.007715	307	2	0	0	91.00
91.01	09101	OP MENTAL HEALTH		0.000000	0	0	0	0	91.01
91.02	09102	DIABETES CENTER		0.000000	1,213	0	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0.000000	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS									
94.00	09400	HOME PROGRAM DIALYSIS		0.000000	0	0	0	0	94.00
200.00		Total (lines 50 through 199)			6,096,881	56	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0213

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part I
Date/Time Prepared:
2/26/2020 4:51 am

			Title XIX		Hospital	PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	9,550,831	0	9,550,831	69,727	136.97	30.00
31.00	INTENSIVE CARE UNIT	2,038,744		2,038,744	8,067	252.73	31.00
40.00	SUBPROVIDER - IPF	665,303	0	665,303	2,016	330.01	40.00
41.00	SUBPROVIDER - IRF	1,576,040	0	1,576,040	7,726	203.99	41.00
42.00	SUBPROVIDER	0	0	0	0	0.00	42.00
43.00	NURSERY	2,646,243		2,646,243	7,557	350.17	43.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
45.00	NURSING FACILITY	0		0	0	0.00	45.00
200.00	Total (lines 30 through 199)	16,477,161		16,477,161	95,093		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	3,188	436,660				
31.00	INTENSIVE CARE UNIT	439	110,948				
40.00	SUBPROVIDER - IPF	671	221,437				
41.00	SUBPROVIDER - IRF	83	16,931				
42.00	SUBPROVIDER	0	0				
43.00	NURSERY	411	143,920				
44.00	SKILLED NURSING FACILITY	0	0				
45.00	NURSING FACILITY	0	0				
200.00	Total (lines 30 through 199)	4,792	929,896				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 14-0213	Period: From 10/01/2018 To 09/30/2019	Worksheet D Part II Date/Time Prepared: 2/26/2020 4:51 am
				Title XIX	Hospital	PPS
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)
		1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	7,491,956	140,498,291	0.053324	0	0 50.00
51.00	05100 RECOVERY ROOM	326,609	33,045,324	0.009884	0	0 51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	528,610	9,678,285	0.054618	0	0 52.00
53.00	05300 ANESTHESIOLOGY	0	0	0.000000	0	0 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	3,547,800	192,446,817	0.018435	0	0 54.00
54.01	05401 ULTRASOUND	347,789	32,072,451	0.010844	0	0 54.01
57.00	05700 CT SCAN	642,147	122,313,052	0.005250	0	0 57.00
58.00	05800 MRI	392,194	34,458,110	0.011382	0	0 58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000	0	0 59.00
60.00	06000 LABORATORY	967,830	176,181,105	0.005493	0	0 60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0	0 60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	118,547	7,940,637	0.014929	0	0 63.00
65.00	06500 RESPIRATORY THERAPY	316,851	15,706,037	0.020174	0	0 65.00
65.01	06501 SLEEP LAB	30,056	3,772,651	0.007967	0	0 65.01
66.00	06600 PHYSICAL THERAPY	161,650	13,720,558	0.011782	0	0 66.00
67.00	06700 OCCUPATIONAL THERAPY	171,734	11,003,713	0.015607	0	0 67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0.000000	0	0 68.00
69.00	06900 ELECTROCARDIOLOGY	352,526	24,418,166	0.014437	0	0 69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	92,288	3,238,109	0.028501	0	0 70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1,412,452	81,437,215	0.017344	0	0 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1,235,428	46,899,059	0.026342	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,771,393	77,221,254	0.022939	0	0 73.00
74.00	07400 RENAL DIALYSIS	208,836	4,634,464	0.045062	0	0 74.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	0	0.000000	0	0 88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0 89.00
90.00	09000 CLINIC	153,386	11,805,883	0.012992	0	0 90.00
90.01	09001 HOMER GLEN LAB	0	0	0.000000	0	0 90.01
90.02	09002 HOMER GLEN FEC	0	0	0.000000	0	0 90.02
90.03	09003 WOMEN'S HEALTH	0	0	0.000000	0	0 90.03
91.00	09100 EMERGENCY	2,692,523	129,442,137	0.020801	0	0 91.00
91.01	09101 OP MENTAL HEALTH	165,291	745,130	0.221828	0	0 91.01
91.02	09102 DIABETES CENTER	19,581	508,992	0.038470	0	0 91.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1,522,612	12,837,675	0.118605	0	0 92.00
OTHER REIMBURSABLE COST CENTERS						
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0.000000	0	0 94.00
200.00	Total (lines 50 through 199)	24,670,089	1,186,025,115		0	0 200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0213		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part III Date/Time Prepared: 2/26/2020 4:51 am	
					Title XIX		Hospital		PPS	
Cost Center Description					Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
					1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	0	0	45.00
200.00		Total (lines 30 through 199)	0	0	0	0	0	0	0	200.00
Cost Center Description					Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
					4.00	5.00	6.00	7.00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0	0	69,727	0.00	3,188	30.00		
31.00	03100	INTENSIVE CARE UNIT	0	0	8,067	0.00	439	31.00		
40.00	04000	SUBPROVIDER - IPF	0	0	2,016	0.00	671	40.00		
41.00	04100	SUBPROVIDER - IRF	0	0	7,726	0.00	83	41.00		
42.00	04200	SUBPROVIDER	0	0	0	0.00	0	42.00		
43.00	04300	NURSERY	0	0	7,557	0.00	411	43.00		
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0.00	0	44.00		
45.00	04500	NURSING FACILITY	0	0	0	0.00	0	45.00		
200.00		Total (lines 30 through 199)	0	0	95,093		4,792	200.00		
Cost Center Description					Inpatient Program Pass-Through Cost (col. 7 x col. 8)					
					9.00					
INPATIENT ROUTINE SERVICE COST CENTERS										
30.00	03000	ADULTS & PEDIATRICS	0					30.00		
31.00	03100	INTENSIVE CARE UNIT	0					31.00		
40.00	04000	SUBPROVIDER - IPF	0					40.00		
41.00	04100	SUBPROVIDER - IRF	0					41.00		
42.00	04200	SUBPROVIDER	0					42.00		
43.00	04300	NURSERY	0					43.00		
44.00	04400	SKILLED NURSING FACILITY	0					44.00		
45.00	04500	NURSING FACILITY	0					45.00		
200.00		Total (lines 30 through 199)	0					200.00		

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0213

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part IV
Date/Time Prepared:
2/26/2020 4:51 am

Cost Center Description		Title XIX			Hospital		PPS	
		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health		
		1.00	2A	2.00	3A	3.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	49,355	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
65.01	06501	SLEEP LAB	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	43,695	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	0	0	998,630	91.00
91.01	09101	OP MENTAL HEALTH	0	0	0	0	0	91.01
91.02	09102	DIABETES CENTER	0	0	0	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
200.00		Total (lines 50 through 199)	0	0	0	0	1,091,680	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0213

Period:
From 10/01/2018
To 09/30/2019Worksheet D
Part IV
Date/Time Prepared:
2/26/2020 4:51 am

Cost Center Description		Title XIX			Hospital		PPS	
		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)		
		4.00	5.00	6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	140,498,291	0.000000	50.00	
51.00	05100	RECOVERY ROOM	0	0	33,045,324	0.000000	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	49,355	9,678,285	0.005100	52.00	
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	192,446,817	0.000000	54.00	
54.01	05401	ULTRASOUND	0	0	32,072,451	0.000000	54.01	
57.00	05700	CT SCAN	0	0	122,313,052	0.000000	57.00	
58.00	05800	MRI	0	0	34,458,110	0.000000	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00	
60.00	06000	LABORATORY	0	0	176,181,105	0.000000	60.00	
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01	
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	7,940,637	0.000000	63.00	
65.00	06500	RESPIRATORY THERAPY	0	0	15,706,037	0.000000	65.00	
65.01	06501	SLEEP LAB	0	0	3,772,651	0.000000	65.01	
66.00	06600	PHYSICAL THERAPY	0	0	13,720,558	0.000000	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0	0	11,003,713	0.000000	67.00	
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	68.00	
69.00	06900	ELECTROCARDIOLOGY	0	43,695	43,695	0.001789	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	3,238,109	0.000000	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	81,437,215	0.000000	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	46,899,059	0.000000	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	77,221,254	0.000000	73.00	
74.00	07400	RENAL DIALYSIS	0	0	4,634,464	0.000000	74.00	
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0.000000	88.00	
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	89.00	
90.00	09000	CLINIC	0	0	11,805,883	0.000000	90.00	
90.01	09001	HOMER GLEN LAB	0	0	0	0.000000	90.01	
90.02	09002	HOMER GLEN FEC	0	0	0	0.000000	90.02	
90.03	09003	WOMEN'S HEALTH	0	0	0	0.000000	90.03	
91.00	09100	EMERGENCY	0	998,630	998,630	0.007715	91.00	
91.01	09101	OP MENTAL HEALTH	0	0	745,130	0.000000	91.01	
91.02	09102	DIABETES CENTER	0	0	508,992	0.000000	91.02	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	12,837,675	0.000000	92.00	
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0.000000	94.00	
200.00		Total (lines 50 through 199)	0	1,091,680	1,091,680	1,186,025,115	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0213		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part IV Date/Time Prepared: 2/26/2020 4:51 am	
				Title XIX		Hospital		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.005100	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	0	54.01
57.00	05700	CT SCAN	0.000000	0	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	0	65.00
65.01	06501	SLEEP LAB	0.000000	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.001789	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	0	89.00
90.00	09000	CLINIC	0.000000	0	0	0	0	0	90.00
90.01	09001	HOMER GLEN LAB	0.000000	0	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0.000000	0	0	0	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0.000000	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.007715	0	0	0	0	0	91.00
91.01	09101	OP MENTAL HEALTH	0.000000	0	0	0	0	0	91.01
91.02	09102	DIABETES CENTER	0.000000	0	0	0	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS									
94.00	09400	HOME PROGRAM DIALYSIS	0.000000	0	0	0	0	0	94.00
200.00		Total (lines 50 through 199)		0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 14-0213 Component CCN: 14-S213	Period: From 10/01/2018 To 09/30/2019	Worksheet D Part II Date/Time Prepared: 2/26/2020 4:51 am	
				Title XIX		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	7,491,956	140,498,291	0.053324	0	0 50.00
51.00	05100	RECOVERY ROOM	326,609	33,045,324	0.009884	0	0 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	528,610	9,678,285	0.054618	0	0 52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,547,800	192,446,817	0.018435	0	0 54.00
54.01	05401	ULTRASOUND	347,789	32,072,451	0.010844	0	0 54.01
57.00	05700	CT SCAN	642,147	122,313,052	0.005250	0	0 57.00
58.00	05800	MRI	392,194	34,458,110	0.011382	0	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0 59.00
60.00	06000	LABORATORY	967,830	176,181,105	0.005493	0	0 60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0 60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	118,547	7,940,637	0.014929	0	0 63.00
65.00	06500	RESPIRATORY THERAPY	316,851	15,706,037	0.020174	0	0 65.00
65.01	06501	SLEEP LAB	30,056	3,772,651	0.007967	0	0 65.01
66.00	06600	PHYSICAL THERAPY	161,650	13,720,558	0.011782	0	0 66.00
67.00	06700	OCCUPATIONAL THERAPY	171,734	11,003,713	0.015607	0	0 67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	352,526	24,418,166	0.014437	0	0 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	92,288	3,238,109	0.028501	0	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,412,452	81,437,215	0.017344	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,235,428	46,899,059	0.026342	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,771,393	77,221,254	0.022939	0	0 73.00
74.00	07400	RENAL DIALYSIS	208,836	4,634,464	0.045062	0	0 74.00
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0 88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0 89.00
90.00	09000	CLINIC	153,386	11,805,883	0.012992	0	0 90.00
90.01	09001	HOMER GLEN LAB	0	0	0.000000	0	0 90.01
90.02	09002	HOMER GLEN FEC	0	0	0.000000	0	0 90.02
90.03	09003	WOMEN'S HEALTH	0	0	0.000000	0	0 90.03
91.00	09100	EMERGENCY	2,692,523	129,442,137	0.020801	0	0 91.00
91.01	09101	OP MENTAL HEALTH	165,291	745,130	0.221828	0	0 91.01
91.02	09102	DIABETES CENTER	19,581	508,992	0.038470	0	0 91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	12,837,675	0.000000	0	0 92.00
	OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0.000000	0	0 94.00
200.00		Total (lines 50 through 199)	23,147,477	1,186,025,115		0	0 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0213 Component CCN: 14-S213		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part IV Date/Time Prepared: 2/26/2020 4:51 am	
			Title XIX		Subprovider - IPF		PPS	
Cost Center Description			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	49,355	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
65.01	06501	SLEEP LAB	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	43,695	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	0	0	998,630	91.00
91.01	09101	OP MENTAL HEALTH	0	0	0	0	0	91.01
91.02	09102	DIABETES CENTER	0	0	0	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
200.00		Total (lines 50 through 199)	0	0	0	0	1,091,680	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0213 Component CCN: 14-S213		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part IV Date/Time Prepared: 2/26/2020 4:51 am	
			Title XIX		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)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	140,498,291	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	33,045,324	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	49,355	49,355	9,678,285	0.005100	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	192,446,817	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	32,072,451	0.000000	54.01
57.00	05700	CT SCAN	0	0	0	122,313,052	0.000000	57.00
58.00	05800	MRI	0	0	0	34,458,110	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	176,181,105	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	7,940,637	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	15,706,037	0.000000	65.00
65.01	06501	SLEEP LAB	0	0	0	3,772,651	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	13,720,558	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	11,003,713	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	43,695	43,695	24,418,166	0.001789	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	3,238,109	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	81,437,215	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	46,899,059	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	77,221,254	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	4,634,464	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000	89.00
90.00	09000	CLINIC	0	0	0	11,805,883	0.000000	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	0.000000	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	0.000000	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0	0	0.000000	90.03
91.00	09100	EMERGENCY	0	998,630	998,630	129,442,137	0.007715	91.00
91.01	09101	OP MENTAL HEALTH	0	0	0	745,130	0.000000	91.01
91.02	09102	DIABETES CENTER	0	0	0	508,992	0.000000	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	12,837,675	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0.000000	94.00
200.00		Total (lines 50 through 199)	0	1,091,680	1,091,680	1,186,025,115		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0213 Component CCN: 14-S213		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part IV Date/Time Prepared: 2/26/2020 4:51 am	
				Title XIX		Subprovider - IPF		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.005100	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	0	54.01
57.00	05700	CT SCAN	0.000000	0	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	0	65.00
65.01	06501	SLEEP LAB	0.000000	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.001789	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	0	89.00
90.00	09000	CLINIC	0.000000	0	0	0	0	0	90.00
90.01	09001	HOMER GLEN LAB	0.000000	0	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0.000000	0	0	0	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0.000000	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.007715	0	0	0	0	0	91.00
91.01	09101	OP MENTAL HEALTH	0.000000	0	0	0	0	0	91.01
91.02	09102	DIABETES CENTER	0.000000	0	0	0	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS									
94.00	09400	HOME PROGRAM DIALYSIS	0.000000	0	0	0	0	0	94.00
200.00		Total (lines 50 through 199)		0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 14-0213	Period: From 10/01/2018 To 09/30/2019	Worksheet D Part II Date/Time Prepared: 2/26/2020 4:51 am
				Component CCN: 14-T213		
				Title XIX	Subprovider - IRF	PPS
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)
		1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,491,956	140,498,291	0.053324	0
51.00	05100	RECOVERY ROOM	326,609	33,045,324	0.009884	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	528,610	9,678,285	0.054618	0
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,547,800	192,446,817	0.018435	0
54.01	05401	ULTRASOUND	347,789	32,072,451	0.010844	0
57.00	05700	CT SCAN	642,147	122,313,052	0.005250	0
58.00	05800	MRI	392,194	34,458,110	0.011382	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0
60.00	06000	LABORATORY	967,830	176,181,105	0.005493	0
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	118,547	7,940,637	0.014929	0
65.00	06500	RESPIRATORY THERAPY	316,851	15,706,037	0.020174	0
65.01	06501	SLEEP LAB	30,056	3,772,651	0.007967	0
66.00	06600	PHYSICAL THERAPY	161,650	13,720,558	0.011782	0
67.00	06700	OCCUPATIONAL THERAPY	171,734	11,003,713	0.015607	0
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0
69.00	06900	ELECTROCARDIOLOGY	352,526	24,418,166	0.014437	0
70.00	07000	ELECTROENCEPHALOGRAPHY	92,288	3,238,109	0.028501	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,412,452	81,437,215	0.017344	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,235,428	46,899,059	0.026342	0
73.00	07300	DRUGS CHARGED TO PATIENTS	1,771,393	77,221,254	0.022939	0
74.00	07400	RENAL DIALYSIS	208,836	4,634,464	0.045062	0
OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0
90.00	09000	CLINIC	153,386	11,805,883	0.012992	0
90.01	09001	HOMER GLEN LAB	0	0	0.000000	0
90.02	09002	HOMER GLEN FEC	0	0	0.000000	0
90.03	09003	WOMEN'S HEALTH	0	0	0.000000	0
91.00	09100	EMERGENCY	2,692,523	129,442,137	0.020801	0
91.01	09101	OP MENTAL HEALTH	165,291	745,130	0.221828	0
91.02	09102	DIABETES CENTER	19,581	508,992	0.038470	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	12,837,675	0.000000	0
OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0.000000	0
200.00		Total (lines 50 through 199)	23,147,477	1,186,025,115		0

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0213 Component CCN: 14-T213		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part IV Date/Time Prepared: 2/26/2020 4:51 am	
			Title XIX		Subprovider - IRF		PPS	
Cost Center Description			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	49,355	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
65.01	06501	SLEEP LAB	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	43,695	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	0	0	998,630	91.00
91.01	09101	OP MENTAL HEALTH	0	0	0	0	0	91.01
91.02	09102	DIABETES CENTER	0	0	0	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
200.00		Total (lines 50 through 199)	0	0	0	0	1,091,680	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0213 Component CCN: 14-T213		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part IV Date/Time Prepared: 2/26/2020 4:51 am	
			Title XIX		Subprovider - IRF		PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	140,498,291	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	33,045,324	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	49,355	49,355	9,678,285	0.005100	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	192,446,817	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	32,072,451	0.000000	54.01
57.00	05700	CT SCAN	0	0	0	122,313,052	0.000000	57.00
58.00	05800	MRI	0	0	0	34,458,110	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	176,181,105	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	7,940,637	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	15,706,037	0.000000	65.00
65.01	06501	SLEEP LAB	0	0	0	3,772,651	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	13,720,558	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	11,003,713	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	43,695	43,695	24,418,166	0.001789	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	3,238,109	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	81,437,215	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	46,899,059	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	77,221,254	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	4,634,464	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000	89.00
90.00	09000	CLINIC	0	0	0	11,805,883	0.000000	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	0.000000	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	0.000000	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0	0	0.000000	90.03
91.00	09100	EMERGENCY	0	998,630	998,630	129,442,137	0.007715	91.00
91.01	09101	OP MENTAL HEALTH	0	0	0	745,130	0.000000	91.01
91.02	09102	DIABETES CENTER	0	0	0	508,992	0.000000	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	12,837,675	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0.000000	94.00
200.00		Total (lines 50 through 199)	0	1,091,680	1,091,680	1,186,025,115		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0213 Component CCN: 14-T213		Period: From 10/01/2018 To 09/30/2019		Worksheet D Part IV Date/Time Prepared: 2/26/2020 4:51 am	
				Title XIX		Subprovider - IRF		PPS	
Cost Center Description			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			9.00	10.00	11.00	12.00	13.00		
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.005100	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	0	54.01
57.00	05700	CT SCAN	0.000000	0	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	0	65.00
65.01	06501	SLEEP LAB	0.000000	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.001789	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS									
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	0	89.00
90.00	09000	CLINIC	0.000000	0	0	0	0	0	90.00
90.01	09001	HOMER GLEN LAB	0.000000	0	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0.000000	0	0	0	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0.000000	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.007715	0	0	0	0	0	91.00
91.01	09101	OP MENTAL HEALTH	0.000000	0	0	0	0	0	91.01
91.02	09102	DIABETES CENTER	0.000000	0	0	0	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS									
94.00	09400	HOME PROGRAM DIALYSIS	0.000000	0	0	0	0	0	94.00
200.00		Total (lines 50 through 199)		0	0	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0213	Period: From 10/01/2018 To 09/30/2019	Worksheet D-1 Date/Time Prepared: 2/26/2020 4:51 am
		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)		69,727	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		69,727	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)		58,611	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)		25,420	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)		72,816,385	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)		72,816,385	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)		72,816,385	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)		1,044.31	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		26,546,360	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		26,546,360	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0213

Period:
From 10/01/2018
To 09/30/2019

Worksheet D-1

Date/Time Prepared:
2/26/2020 4:51 am

		Title XVIII		Hospital	PPS	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	17,365,334	8,067	2,152.64	3,370	7,254,397
44.00	CORONARY CARE UNIT					
45.00	BURN INTENSIVE CARE UNIT					
46.00	SURGICAL INTENSIVE CARE UNIT					
47.00	OTHER SPECIAL CARE (SPECIFY)					
Cost Center Description						1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					41,296,883
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					75,097,640
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					4,333,477
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					3,835,926
52.00	Total Program excludable cost (sum of lines 50 and 51)					8,169,403
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					66,928,237
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program discharges					0
55.00	Target amount per discharge					0.00
56.00	Target amount (line 54 x line 55)					0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00	Bonus payment (see instructions)					0
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0
62.00	Relief payment (see instructions)					0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00	Program routine service cost (line 9 x line 71)					72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00	Program capital-related costs (line 9 x line 76)					77.00
78.00	Inpatient routine service cost (line 74 minus line 77)					78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00	Inpatient routine service cost per diem limitation					81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00	Reasonable inpatient routine service costs (see instructions)					83.00
84.00	Program inpatient ancillary services (see instructions)					84.00
85.00	Utilization review - physician compensation (see instructions)					85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00	Total observation bed days (see instructions)					11,116
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,044.31
89.00	Observation bed cost (line 87 x line 88) (see instructions)					11,608,550

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0213		Period: From 10/01/2018 To 09/30/2019		Worksheet D-1 Date/Time Prepared: 2/26/2020 4:51 am	
				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	9,550,831	72,816,385	0.131163	11,608,550	1,522,612			90.00
91.00	Nursing School cost	0	72,816,385	0.000000	11,608,550	0			91.00
92.00	Allied health cost	0	72,816,385	0.000000	11,608,550	0			92.00
93.00	All other Medical Education	0	72,816,385	0.000000	11,608,550	0			93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0213 Component CCN: 14-S213	Period: From 10/01/2018 To 09/30/2019	Worksheet D-1 Date/Time Prepared: 2/26/2020 4:51 am
		Title XVIII	Subprovider - IPF	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,016	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,016	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		2,016	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)		319	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)		3,074,733	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)		3,074,733	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)		3,074,733	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)		1,525.17	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		486,529	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)		486,529	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0213 Component CCN: 14-S213	Period: From 10/01/2018 To 09/30/2019	Worksheet D-1 Date/Time Prepared: 2/26/2020 4:51 am
			Title XVIII	Subprovider - IPF	PPS
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0
Intensive Care Type Inpatient Hospital Units					
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0
44.00 CORONARY CARE UNIT					
45.00 BURN INTENSIVE CARE UNIT					
46.00 SURGICAL INTENSIVE CARE UNIT					
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)					25,926
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					512,455
PASS THROUGH COST ADJUSTMENTS					
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					105,273
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					2,959
52.00 Total Program excludable cost (sum of lines 50 and 51)					108,232
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					404,223
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: 14-0213 Component CCN: 14-S213		Period: From 10/01/2018 To 09/30/2019		Worksheet D-1 Date/Time Prepared: 2/26/2020 4:51 am	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	665,303	3,074,733	0.216377	0	0	90.00
91.00	Nursing School cost	0	3,074,733	0.000000	0	0	91.00
92.00	Allied health cost	0	3,074,733	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,074,733	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0213 Component CCN: 14-T213	Period: From 10/01/2018 To 09/30/2019	Worksheet D-1 Date/Time Prepared: 2/26/2020 4:51 am
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		7,726	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		7,726	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)		7,726	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)		4,990	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		10,391,451	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		10,391,451	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		10,391,451	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)		1,345.00	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		6,711,550	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		6,711,550	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0213 Component CCN: 14-T213	Period: From 10/01/2018 To 09/30/2019	Worksheet D-1 Date/Time Prepared: 2/26/2020 4:51 am
			Title XVIII	Subprovider - IRF	PPS
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0
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					
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)					1,330,127
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					8,041,677
PASS THROUGH COST ADJUSTMENTS					
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					1,017,910
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					83,671
52.00 Total Program excludable cost (sum of lines 50 and 51)					1,101,581
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					6,940,096
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: 14-0213 Component CCN: 14-T213		Period: From 10/01/2018 To 09/30/2019		Worksheet D-1 Date/Time Prepared: 2/26/2020 4:51 am	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,576,040	10,391,451	0.151667	0	0	90.00
91.00	Nursing School cost	0	10,391,451	0.000000	0	0	91.00
92.00	Allied health cost	0	10,391,451	0.000000	0	0	92.00
93.00	All other Medical Education	0	10,391,451	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0213	Period: From 10/01/2018 To 09/30/2019	Worksheet D-1 Date/Time Prepared: 2/26/2020 4:51 am
Cost Center Description		Title XIX	Hospital	PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		69,727	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		69,727	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)		58,611	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)		3,188	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		7,557	15.00
16.00	Nursery days (title V or XIX only)		411	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)		72,816,385	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)		72,816,385	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)		72,816,385	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)		1,044.31	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		3,329,260	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)		3,329,260	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0213

Period:
From 10/01/2018
To 09/30/2019

Worksheet D-1

Date/Time Prepared:
2/26/2020 4:51 am

			Title XIX		Hospital	PPS	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	10,235,625	7,557	1,354.46	411	556,683	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	17,365,334	8,067	2,152.64	439	945,009	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
							1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						0
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						4,830,952
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						691,528
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						0
52.00	Total Program excludable cost (sum of lines 50 and 51)						691,528
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						4,139,424
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)						11,116
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						1,044.31
89.00	Observation bed cost (line 87 x line 88) (see instructions)						11,608,550

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0213

Period:
From 10/01/2018
To 09/30/2019

Worksheet D-1

Date/Time Prepared:
2/26/2020 4:51 am

Cost Center Description		Title XIX		Hospital	PPS	
		Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	9,550,831	72,816,385	0.131163	11,608,550	1,522,612
91.00	Nursing School cost	0	72,816,385	0.000000	11,608,550	0
92.00	Allied health cost	0	72,816,385	0.000000	11,608,550	0
93.00	All other Medical Education	0	72,816,385	0.000000	11,608,550	0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0213 Component CCN: 14-S213	Period: From 10/01/2018 To 09/30/2019	Worksheet D-1 Date/Time Prepared: 2/26/2020 4:51 am
		Title XIX	Subprovider - IPF	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,016	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,016	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		2,016	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)		671	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		7,557	15.00
16.00	Nursery days (title V or XIX only)		411	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)		3,074,733	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)		3,074,733	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)		3,074,733	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)		1,525.17	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,023,389	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,023,389	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0213 Component CCN: 14-S213	Period: From 10/01/2018 To 09/30/2019	Worksheet D-1 Date/Time Prepared: 2/26/2020 4:51 am
			Title XIX	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					
47.00 OTHER SPECIAL CARE (SPECIFY)					
Cost Center Description					1.00
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,023,389
PASS THROUGH COST ADJUSTMENTS					
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					221,437
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0
52.00 Total Program excludable cost (sum of lines 50 and 51)					221,437
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					801,952
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: 14-0213 Component CCN: 14-S213		Period: From 10/01/2018 To 09/30/2019		Worksheet D-1 Date/Time Prepared: 2/26/2020 4:51 am	
		Title XIX		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	665,303	3,074,733	0.216377	0	0	90.00
91.00	Nursing School cost	0	3,074,733	0.000000	0	0	91.00
92.00	Allied health cost	0	3,074,733	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,074,733	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0213 Component CCN: 14-T213	Period: From 10/01/2018 To 09/30/2019	Worksheet D-1 Date/Time Prepared: 2/26/2020 4:51 am
		Title XIX	Subprovider - IRF	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		7,726	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		7,726	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)		7,726	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)		83	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		7,557	15.00
16.00	Nursery days (title V or XIX only)		411	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		10,391,451	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		10,391,451	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		10,391,451	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)		1,345.00	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		111,635	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)		111,635	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0213 Component CCN: 14-T213	Period: From 10/01/2018 To 09/30/2019	Worksheet D-1 Date/Time Prepared: 2/26/2020 4:51 am
			Title XIX	Subprovider - IRF	PPS
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0
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					
47.00 OTHER SPECIAL CARE (SPECIFY)					
Cost Center Description					1.00
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					111,635
PASS THROUGH COST ADJUSTMENTS					
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					16,931
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0
52.00 Total Program excludable cost (sum of lines 50 and 51)					16,931
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					94,704
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00 Program discharges					0
55.00 Target amount per discharge					0.00
56.00 Target amount (line 54 x line 55)					0
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0
58.00 Bonus payment (see instructions)					0
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0
62.00 Relief payment (see instructions)					0
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0
PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY					
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					71.00
72.00 Program routine service cost (line 9 x line 71)					72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)					73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)					74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)					76.00
77.00 Program capital-related costs (line 9 x line 76)					77.00
78.00 Inpatient routine service cost (line 74 minus line 77)					78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)					79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					80.00
81.00 Inpatient routine service cost per diem limitation					81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)					82.00
83.00 Reasonable inpatient routine service costs (see instructions)					83.00
84.00 Program inpatient ancillary services (see instructions)					84.00
85.00 Utilization review - physician compensation (see instructions)					85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)					86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00 Total observation bed days (see instructions)					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: 14-0213 Component CCN: 14-T213		Period: From 10/01/2018 To 09/30/2019	Worksheet D-1 Date/Time Prepared: 2/26/2020 4:51 am	
		Title XIX		Subprovider - IRF	PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00 Capital-related cost	1,576,040	10,391,451	0.151667	0	0	90.00
91.00 Nursing School cost	0	10,391,451	0.000000	0	0	91.00
92.00 Allied health cost	0	10,391,451	0.000000	0	0	92.00
93.00 All other Medical Education	0	10,391,451	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0213	Period: From 10/01/2018 To 09/30/2019	Worksheet D-3 Date/Time Prepared: 2/26/2020 4:51 am
			Title XVIII	Hospital	PPS
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
			1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		29,132,631	30.00
31.00	03100	INTENSIVE CARE UNIT		9,422,344	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		2,651,867	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.316159	19,401,019	50.00
51.00	05100	RECOVERY ROOM	0.088881	5,089,512	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.806158	1,843	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.150334	21,026,855	54.00
54.01	05401	ULTRASOUND	0.089619	4,283,921	54.01
57.00	05700	CT SCAN	0.034315	17,906,783	57.00
58.00	05800	MRI	0.068025	4,392,181	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.090970	27,456,202	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.304512	2,089,261	63.00
65.00	06500	RESPIRATORY THERAPY	0.252835	6,102,407	65.00
65.01	06501	SLEEP LAB	0.172107	0	65.01
66.00	06600	PHYSICAL THERAPY	0.243897	4,505,123	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.301264	706	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.120954	6,674,311	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.331869	416,869	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.270455	15,703,793	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.634717	14,516,698	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.352866	16,345,157	73.00
74.00	07400	RENAL DIALYSIS	0.286146	2,238,424	74.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
90.00	09000	CLINIC	0.301365	31	90.00
90.01	09001	HOMER GLEN LAB	0.000000	0	90.01
90.02	09002	HOMER GLEN FEC	0.000000	0	90.02
90.03	09003	WOMEN'S HEALTH	0.000000	0	90.03
91.00	09100	EMERGENCY	0.177126	16,088,372	91.00
91.01	09101	OP MENTAL HEALTH	0.827587	0	91.01
91.02	09102	DIABETES CENTER	0.836716	16,450	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.904256	881,175	92.00
OTHER REIMBURSABLE COST CENTERS					
94.00	09400	HOME PROGRAM DIALYSIS	0.000000	0	94.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		185,137,093	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)		185,137,093	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0213 Component CCN: 14-S213	Period: From 10/01/2018 To 09/30/2019	Worksheet D-3 Date/Time Prepared: 2/26/2020 4:51 am	
		Title XVIII	Subprovider - IPF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
40.00	04000 SUBPROVIDER - IPF		359,062		40.00
41.00	04100 SUBPROVIDER - IRF		501		41.00
42.00	04200 SUBPROVIDER		0		42.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.316159	500	158	50.00
51.00	05100 RECOVERY ROOM	0.088881	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.806158	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.150334	2,641	397	54.00
54.01	05401 ULTRASOUND	0.089619	0	0	54.01
57.00	05700 CT SCAN	0.034315	9,082	312	57.00
58.00	05800 MRI	0.068025	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000 LABORATORY	0.090970	79,583	7,240	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.304512	2,016	614	63.00
65.00	06500 RESPIRATORY THERAPY	0.252835	2,790	705	65.00
65.01	06501 SLEEP LAB	0.172107	0	0	65.01
66.00	06600 PHYSICAL THERAPY	0.243897	1,074	262	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.301264	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.120954	4,214	510	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.331869	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.270455	1,844	499	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.634717	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.352866	7,521	2,654	73.00
74.00	07400 RENAL DIALYSIS	0.286146	0	0	74.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000 CLINIC	0.301365	0	0	90.00
90.01	09001 HOMER GLEN LAB	0.000000	0	0	90.01
90.02	09002 HOMER GLEN FEC	0.000000	0	0	90.02
90.03	09003 WOMEN'S HEALTH	0.000000	0	0	90.03
91.00	09100 EMERGENCY	0.177126	70,993	12,575	91.00
91.01	09101 OP MENTAL HEALTH	0.827587	0	0	91.01
91.02	09102 DIABETES CENTER	0.836716	0	0	91.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.904256	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
94.00	09400 HOME PROGRAM DIALYSIS	0.000000	0	0	94.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		182,258	25,926	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)		182,258		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0213 Component CCN: 14-T213	Period: From 10/01/2018 To 09/30/2019	Worksheet D-3 Date/Time Prepared: 2/26/2020 4:51 am	
		Title XVIII	Subprovider - IRF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
40.00	04000 SUBPROVIDER - IPF		0		40.00
41.00	04100 SUBPROVIDER - IRF		8,681,579		41.00
42.00	04200 SUBPROVIDER		0		42.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.316159	7,572	2,394	50.00
51.00	05100 RECOVERY ROOM	0.088881	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.806158	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.150334	105,344	15,837	54.00
54.01	05401 ULTRASOUND	0.089619	81,201	7,277	54.01
57.00	05700 CT SCAN	0.034315	178,812	6,136	57.00
58.00	05800 MRI	0.068025	82,240	5,594	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000 LABORATORY	0.090970	1,073,334	97,641	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.304512	47,332	14,413	63.00
65.00	06500 RESPIRATORY THERAPY	0.252835	304,868	77,081	65.00
65.01	06501 SLEEP LAB	0.172107	0	0	65.01
66.00	06600 PHYSICAL THERAPY	0.243897	3,069,270	748,586	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.301264	320	96	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.120954	30,427	3,680	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.331869	11,329	3,760	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.270455	325,294	87,977	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.634717	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.352866	538,949	190,177	73.00
74.00	07400 RENAL DIALYSIS	0.286146	239,069	68,409	74.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000 CLINIC	0.301365	0	0	90.00
90.01	09001 HOMER GLEN LAB	0.000000	0	0	90.01
90.02	09002 HOMER GLEN FEC	0.000000	0	0	90.02
90.03	09003 WOMEN'S HEALTH	0.000000	0	0	90.03
91.00	09100 EMERGENCY	0.177126	307	54	91.00
91.01	09101 OP MENTAL HEALTH	0.827587	0	0	91.01
91.02	09102 DIABETES CENTER	0.836716	1,213	1,015	91.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.904256	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
94.00	09400 HOME PROGRAM DIALYSIS	0.000000	0	0	94.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		6,096,881	1,330,127	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)		6,096,881		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0213	Period: From 10/01/2018 To 09/30/2019	Worksheet E Part A Date/Time Prepared: 2/26/2020 4:51 am
		Title XVIII	Hospital	PPS
			1.00	
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
1.00	DRG Amounts Other than Outlier Payments		0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	62,994,668		1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0		1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0		1.04
2.00	Outlier payments for discharges. (see instructions)			2.00
2.01	Outlier reconciliation amount	0		2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)	0		2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)	0		2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)	550,550		2.04
3.00	Managed Care Simulated Payments	0		3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	227.08		4.00
Indirect Medical Education Adjustment				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)		0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	28.01
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		0	29.01
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		1.84	30.00
31.00	Percentage of Medicaid patient days (see instructions)		14.87	31.00
32.00	Sum of lines 30 and 31		16.71	32.00
33.00	Allowable disproportionate share percentage (see instructions)		3.61	33.00
34.00	Disproportionate share adjustment (see instructions)		568,527	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0213	Period: From 10/01/2018 To 09/30/2019	Worksheet E Part A Date/Time Prepared: 2/26/2020 4:51 am	
		Title XVIII	Hospital	PPS	
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)		0	0	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000		35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		0	2,734,791	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		0	2,734,791	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		2,734,791		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0		40.00
			Before 1/1	On/After 1/1	
			1.00	1.01	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00			42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0			43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000			44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00		0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0			46.00
47.00	Subtotal (see instructions)	66,848,536			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)			66,848,536	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			5,361,803	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)			0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).			0	52.00
53.00	Nursing and Allied Health Managed Care payment			85,407	53.00
54.00	Special add-on payments for new technologies			0	54.00
54.01	Islet isolation add-on payment			0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)			0	55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)			0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).			0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)			136,071	58.00
59.00	Total (sum of amounts on lines 49 through 58)			72,431,817	59.00
60.00	Primary payer payments			95,113	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			72,336,704	61.00
62.00	Deductibles billed to program beneficiaries			6,944,042	62.00
63.00	Coinsurance billed to program beneficiaries			97,064	63.00
64.00	Allowable bad debts (see instructions)			1,056,609	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			686,796	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			439,513	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			65,982,394	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)			0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)			0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	70.00
70.50	Rural Community Hospital Demonstration Project (\$410A Demonstration) adjustment (see instructions)			0	70.50
70.87	Demonstration payment adjustment amount before sequestration			0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)			0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)				70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)			0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)			0	70.91
70.92	Bundled Model 1 discount amount (see instructions)			0	70.92
70.93	HVBP payment adjustment amount (see instructions)			224,274	70.93
70.94	HRR adjustment amount (see instructions)			-31,500	70.94
70.95	Recovery of accelerated depreciation			0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0213	Period: From 10/01/2018 To 09/30/2019	Worksheet E Part A Date/Time Prepared: 2/26/2020 4:51 am	
		Title XVIII	Hospital	PPS	
		FFY (yyyy)	Amount		
		0	1.00		
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96	
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97	
70.98	Low Volume Payment-3		0	70.98	
70.99	HAC adjustment amount (see instructions)		0	70.99	
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		66,175,168	71.00	
71.01	Sequestration adjustment (see instructions)		1,323,503	71.01	
71.02	Demonstration payment adjustment amount after sequestration		0	71.02	
72.00	Interim payments		64,777,292	72.00	
73.00	Tentative settlement (for contractor use only)		0	73.00	
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		74,373	74.00	
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		2,233,856	75.00	
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00	
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00	
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00	
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00	
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00	
95.00	Time value of money for operating expenses (see instructions)		0	95.00	
96.00	Time value of money for capital related expenses (see instructions)		0	96.00	
		Prior to 10/1	On/After 10/1		
		1.00	2.00		
HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)			0	100.00
HVBP Adjustment for HSP Bonus Payment					
101.00	HVBP adjustment factor (see instructions)		0.0000000000	101.00	
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)			0	102.00
HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)		0.0000	103.00	
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	104.00	
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment					
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.				200.00
Cost Reimbursement					
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)				201.00
202.00	Medicare discharges (see instructions)				202.00
203.00	Case-mix adjustment factor (see instructions)				203.00
Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)					
204.00	Medicare target amount				204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)				205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)				206.00
Adjustment to Medicare Part A Inpatient Reimbursement					
207.00	Program reimbursement under the §410A Demonstration (see instructions)				207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)				208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)				209.00
210.00	Reserved for future use				210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)				211.00
Comparison of PPS versus Cost Reimbursement					
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)				212.00
213.00	Low-volume adjustment (see instructions)				213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)				218.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0213

Period:
From 10/01/2018
To 09/30/2019Worksheet E
Part A Exhibit 4
Date/Time Prepared:
2/26/2020 4:51 am

		Title XVIII		Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)
		0	1.00	2.00	3.00	4.00	5.00
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	0	0	0	0
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	62,994,668	0	0	62,994,668	62,994,668
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0	0	0
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0	0	0	0
2.00	Outlier payments for discharges (see instructions)	2.00					
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	0	0	550,550	0	0
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	550,550	0	0	0	0
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0
4.00	Managed care simulated payments	3.00	0	0	0	0	0
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000	0.000000
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000	0.000000
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0361	0.0361	0.0361	0.0361	0.0361
11.00	Disproportionate share adjustment (see instructions)	34.00	568,527	0	0	568,527	568,527
11.01	Uncompensated care payments	36.00	2,734,791	0	0	2,734,791	2,734,791
Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0
13.00	Subtotal (see instructions)	47.00	66,848,536	0	550,550	66,297,986	66,848,536
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0
15.00	Total payment for inpatient operating costs (see instructions)	49.00	66,848,536	0	550,550	66,297,986	66,848,536
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	5,361,803	0	0	5,361,803	5,361,803

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0213

Period:
From 10/01/2018
To 09/30/2019Worksheet E
Part A Exhibit 4
Date/Time Prepared:
2/26/2020 4:51 am

				Title XVIII		Hospital	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	550,550	71,659,789	72,210,339	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	5,125,214	0	0	5,125,214	5,125,214	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	60,282	0	0	60,282	60,282	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0344	0.0344	0.0344	0.0344		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	176,307	0	0	176,307	176,307	25.00
26.00	Total prospective capital payments (see instructions)	12.00	5,361,803	0	0	5,361,803	5,361,803	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0213

Period:
From 10/01/2018
To 09/30/2019Worksheet E
Part A Exhibit 5
Date/Time Prepared:
2/26/2020 4:51 am

		Title XVIII		Hospital		PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	0		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	62,994,668		62,994,668	62,994,668	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	0	550,550		0	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	550,550		0	0	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0361	0.0361	0.0361		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	568,527	0	568,527	568,527	11.00
11.01	Uncompensated care payments	36.00	2,734,791	0	2,734,791	2,734,791	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	66,848,536	550,550	66,297,986	66,848,536	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	66,848,536	550,550	66,297,986	66,848,536	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	5,361,803	0	5,361,803	5,361,803	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			550,550	71,659,789	72,210,339	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0213

Period:
From 10/01/2018
To 09/30/2019Worksheet E
Part A Exhibit 5
Date/Time Prepared:
2/26/2020 4:51 am

		Title XVIII		Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	5,125,214	0	5,125,214	5,125,214	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	60,282	0	60,282	60,282	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0344	0.0344	0.0344		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	176,307	0	176,307	176,307	25.00
26.00	Total prospective capital payments (see instructions)	12.00	5,361,803	0	5,361,803	5,361,803	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	224,274	0	224,274	224,274	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	-31,500	0	-31,500	-31,500	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0213	Period: From 10/01/2018 To 09/30/2019	Worksheet E Part B Date/Time Prepared: 2/26/2020 4:51 am
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		46,396	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		30,841,328	2.00
3.00	OPPS payments		34,222,847	3.00
4.00	Outlier payment (see instructions)		38,501	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		118,549	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		46,396	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		98,899	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)		98,899	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)		98,899	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		52,503	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)		46,396	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)		34,379,897	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		12,068	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		6,230,076	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)		28,184,149	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)		28,184,149	30.00
31.00	Primary payer payments		5,202	31.00
32.00	Subtotal (line 30 minus line 31)		28,178,947	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)		619,506	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		402,679	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		331,222	36.00
37.00	Subtotal (see instructions)		28,581,626	37.00
38.00	MSP-LCC reconciliation amount from PS&R		-28	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		28,581,654	40.00
40.01	Sequestration adjustment (see instructions)		571,633	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
41.00	Interim payments		27,994,051	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		15,970	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		595,873	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0213

Period:
From 10/01/2018
To 09/30/2019Worksheet E-1
Part I
Date/Time Prepared:
2/26/2020 4:51 am

		Title XVIII		Hospital		PPS
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		64,777,292		27,994,051	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)		64,777,292		27,994,051	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		74,373		15,970	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		64,851,665		28,010,021	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

 Provider CCN: 14-0213
 Component CCN: 14-S213

 Period:
 From 10/01/2018
 To 09/30/2019

 Worksheet E-1
 Part I
 Date/Time Prepared:
 2/26/2020 4:51 am

		Title XVIII		Subprovider - IPF		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		250,571		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)		250,571		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		33,094		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		283,665		0	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor						

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN: 14-0213 Component CCN: 14-T213		Period: From 10/01/2018 To 09/30/2019		Worksheet E-1 Part I Date/Time Prepared: 2/26/2020 4:51 am	
		Title XVIII		Subprovider - IRF		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider					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		8,047,136			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)		8,047,136			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		9,617			0	6.01
6.02	SETTLEMENT TO PROGRAM		0			0	6.02
7.00	Total Medicare program liability (see instructions)		8,056,753			0	7.00
				Contractor Number		NPR Date (Mo/Day/Yr)	
		0		1.00		2.00	
8.00	Name of Contractor					8.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 14-0213	Period: From 10/01/2018 To 09/30/2019	Worksheet E-1 Part II Date/Time Prepared: 2/26/2020 4:51 am	
		Title XVIII	Hospital	PPS	
				1.00	
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS					
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION					
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14				1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12				2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12				4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20				6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168				7.00
8.00	Calculation of the HIT incentive payment (see instructions)				8.00
9.00	Sequestration adjustment amount (see instructions)				9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)				10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH					
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
31.00	Other Adjustment (specify)				31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)				32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0213 Component CCN: 14-S213	Period: From 10/01/2018 To 09/30/2019	Worksheet E-3 Part II Date/Time Prepared: 2/26/2020 4:51 am
		Title XVIII	Subprovider - IPF	PPS
				1.00
PART II - MEDICARE PART A SERVICES - IPF PPS				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)			296,059 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)			5.523288 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)			296,059 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)			296,059 16.00
17.00	Primary payer payments			0 17.00
18.00	Subtotal (line 16 less line 17).			296,059 18.00
19.00	Deductibles			40,368 19.00
20.00	Subtotal (line 18 minus line 19)			255,691 20.00
21.00	Coinsurance			0 21.00
22.00	Subtotal (line 20 minus line 21)			255,691 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			51,087 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			33,207 24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			18,470 25.00
26.00	Subtotal (sum of lines 22 and 24)			288,898 26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0 27.00
28.00	Other pass through costs (see instructions)			556 28.00
29.00	Outlier payments reconciliation			0 29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 30.50
30.99	Demonstration payment adjustment amount before sequestration			0 30.99
31.00	Total amount payable to the provider (see instructions)			289,454 31.00
31.01	Sequestration adjustment (see instructions)			5,789 31.01
31.02	Demonstration payment adjustment amount after sequestration			0 31.02
32.00	Interim payments			250,571 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)			33,094 34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			1,801 35.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2			0 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0213 Component CCN: 14-T213	Period: From 10/01/2018 To 09/30/2019	Worksheet E-3 Part III Date/Time Prepared: 2/26/2020 4:51 am
		Title XVIII	Subprovider - IRF	PPS
				1.00
PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)		7,984,616	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)		0.0025	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)		62,280	3.00
4.00	Outlier Payments		214,554	4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)		0.00	5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)		0.00	5.01
6.00	New Teaching program adjustment. (see instructions)		0.00	6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)		0.00	7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)		0.00	8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)		0.00	9.00
10.00	Average Daily Census (see instructions)		21.167123	10.00
11.00	Teaching Adjustment Factor (see instructions)		0.000000	11.00
12.00	Teaching Adjustment (see instructions)		0	12.00
13.00	Total PPS Payment (see instructions)		8,261,450	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)		0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)			15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)		0	16.00
17.00	Subtotal (see instructions)		8,261,450	17.00
18.00	Primary payer payments		0	18.00
19.00	Subtotal (line 17 less line 18).		8,261,450	19.00
20.00	Deductibles		12,228	20.00
21.00	Subtotal (line 19 minus line 20)		8,249,222	21.00
22.00	Coinurance		31,569	22.00
23.00	Subtotal (line 21 minus line 22)		8,217,653	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		5,336	24.00
25.00	Adjusted reimbursable bad debts (see instructions)		3,468	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	26.00
27.00	Subtotal (sum of lines 23 and 25)		8,221,121	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)		0	28.00
29.00	Other pass through costs (see instructions)		56	29.00
30.00	Outlier payments reconciliation		0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	31.50
31.99	Demonstration payment adjustment amount before sequestration		0	31.99
32.00	Total amount payable to the provider (see instructions)		8,221,177	32.00
32.01	Sequestration adjustment (see instructions)		164,424	32.01
32.02	Demonstration payment adjustment amount after sequestration		0	32.02
33.00	Interim payments		8,047,136	33.00
34.00	Tentative settlement (for contractor use only)		0	34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)		9,617	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	36.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4		214,554	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

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

Provider CCN: 14-0213

Period:
From 10/01/2018
To 09/30/2019

Worksheet G

Date/Time Prepared:
2/26/2020 4:51 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	22,458,000	0	0	0	1.00
2.00	Temporary investments	2,220,000	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	45,795,000	0	0	0	4.00
5.00	Other receivable	965,000	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	6,634,000	0	0	0	8.00
9.00	Other current assets	33,009,000	0	0	0	9.00
10.00	Due from other funds	42,421,000	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	153,502,000	0	0	0	11.00
FIXED ASSETS						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	641,227,570	0	0	0	15.00
16.00	Accumulated depreciation	-244,607,570	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	396,620,000	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	269,632,000	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	269,632,000	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	819,754,000	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	40,553,000	0	0	0	37.00
38.00	Salaries, wages, and fees payable	19,052,000	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	7,715,000	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	43,975,000	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	111,295,000	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	375,207,000	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	5,124,000	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	380,331,000	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	491,626,000	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	328,128,000				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	328,128,000	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	819,754,000	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0213

Period:
From 10/01/2018
To 09/30/2019

Worksheet G-1

Date/Time Prepared:
2/26/2020 4:51 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		294,717,000		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		32,336,000				2.00
3.00	Total (sum of line 1 and line 2)		327,053,000		0		3.00
4.00	NET ASSETS WITH DONOR RESTRICTIONS	456,000		0		0	4.00
5.00	NET ASSETS RELEASED FROM RESTRICTION	619,000		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		1,075,000		0		10.00
11.00	Subtotal (line 3 plus line 10)		328,128,000		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		328,128,000		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	NET ASSETS WITH DONOR RESTRICTIONS		0				4.00
5.00	NET ASSETS RELEASED FROM RESTRICTION		0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-0213

Period:
From 10/01/2018
To 09/30/2019Worksheet G-2
Parts I & II
Date/Time Prepared:
2/26/2020 4:51 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	66,227,040		66,227,040	1.00
2.00	SUBPROVIDER - IPF	2,273,221		2,273,221	2.00
3.00	SUBPROVIDER - IRF	18,456,014		18,456,014	3.00
4.00	SUBPROVIDER	0		0	4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	0		0	7.00
8.00	NURSING FACILITY	0		0	8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	86,956,275		86,956,275	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	21,621,553		21,621,553	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	21,621,553		21,621,553	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	108,577,828		108,577,828	17.00
18.00	Ancillary services	417,738,417	612,946,879	1,030,685,296	18.00
19.00	Outpatient services	37,670,332	107,478,125	145,148,457	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		5,924,947	5,924,947	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC		0	0	24.00
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	NURSERY	10,383,947	0	10,383,947	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	574,370,524	726,349,951	1,300,720,475	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		385,920,306		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		385,920,306		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0213

Period:
From 10/01/2018
To 09/30/2019

Worksheet G-3

Date/Time Prepared:
2/26/2020 4:51 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	1,300,720,475	1.00
2.00	Less contractual allowances and discounts on patients' accounts	864,166,588	2.00
3.00	Net patient revenues (line 1 minus line 2)	436,553,887	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	385,920,306	4.00
5.00	Net income from service to patients (line 3 minus line 4)	50,633,581	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISC - OTHER REVENUE	6,717,000	24.00
24.01	NON-OPERATING INCOME	9,741,000	24.01
24.02	REVENUE RECLASS	1,162,001	24.02
24.03	ROUNDING	235	24.03
25.00	Total other income (sum of lines 6-24)	17,620,236	25.00
26.00	Total (line 5 plus line 25)	68,253,817	26.00
27.00	BAD DEBTS	13,437,205	27.00
27.01	JOINT VENTURE RECLASS	22,480,612	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	35,917,817	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	32,336,000	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS					Provider CCN: 14-0213 HHA CCN: 14-7452	Period: From 10/01/2018 To 09/30/2019	Worksheet H Date/Time Prepared: 2/26/2020 4:51 am
						Home Health Agency I	PPS
	Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Pur chased Services	Other Costs	Total (sum of cols. 1 thru 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures		0		0	0	1.00
2.00	Capital Related - Movable Equipment		0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	4.00
5.00	Administrative and General	676,694	0	0	59	57,012	5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	64,132	0	97,565	161,697	6.00
7.00	Physical Therapy	0	7,167	1,003,990	0	1,011,157	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	1,505,120	0	0	760	1,505,880	10.00
11.00	Home Health Aide	51,834	8,228	0	710	60,772	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	2,233,648	79,527	1,004,049	156,047	3,473,271	24.00
	Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
	7.00	8.00	9.00	10.00			
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0		1.00
2.00	Capital Related - Movable Equipment	0	0	0	0		2.00
3.00	Plant Operation & Maintenance	0	0	0	0		3.00
4.00	Transportation	0	0	0	0		4.00
5.00	Administrative and General	23,878	757,643	0	757,643		5.00
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	161,697	0	161,697		6.00
7.00	Physical Therapy	0	1,011,157	0	1,011,157		7.00
8.00	Occupational Therapy	0	0	0	0		8.00
9.00	Speech Pathology	0	0	0	0		9.00
10.00	Medical Social Services	0	1,505,880	0	1,505,880		10.00
11.00	Home Health Aide	0	60,772	0	60,772		11.00
12.00	Supplies (see instructions)	0	0	0	0		12.00
13.00	Drugs	0	0	0	0		13.00
14.00	DME	0	0	0	0		14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0		15.00
16.00	Respiratory Therapy	0	0	0	0		16.00
17.00	Private Duty Nursing	0	0	0	0		17.00
18.00	Clinic	0	0	0	0		18.00
19.00	Health Promotion Activities	0	0	0	0		19.00
20.00	Day Care Program	0	0	0	0		20.00
21.00	Home Delivered Meals Program	0	0	0	0		21.00
22.00	Homemaker Service	0	0	0	0		22.00
23.00	All Others (specify)	0	0	0	0		23.00
23.50	Telemedicine	0	0	0	0		23.50
24.00	Total (sum of lines 1-23)	23,878	3,497,149	0	3,497,149		24.00

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

COST ALLOCATION - HHA GENERAL SERVICE COST

Provider CCN: 14-0213

Period:

Worksheet H-1

HHA CCN: 14-7452

From 10/01/2018

Part I

To 09/30/2019

Date/Time Prepared:

2/26/2020 4:51 am

Home Health
Agency I

PPS

		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation		
			Bldgs & Fixtures	Movable Equipment			Subtotal (cols. 0-4)	
							0	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	757,643	0	0	0	0	757,643	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	161,697	0	0	0	0	161,697	6.00
7.00	Physical Therapy	1,011,157	0	0	0	0	1,011,157	7.00
8.00	Occupational Therapy	0	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	1,505,880	0	0	0	0	1,505,880	10.00
11.00	Home Health Aide	60,772	0	0	0	0	60,772	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	3,497,149	0	0	0	0	3,497,149	24.00
		Administrative & General	Total (cols. 4A + 5)					
		5.00	6.00					
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures							1.00
2.00	Capital Related - Movable Equipment							2.00
3.00	Plant Operation & Maintenance							3.00
4.00	Transportation							4.00
5.00	Administrative and General	757,643						5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	44,719	206,416					6.00
7.00	Physical Therapy	279,648	1,290,805					7.00
8.00	Occupational Therapy	0	0					8.00
9.00	Speech Pathology	0	0					9.00
10.00	Medical Social Services	416,469	1,922,349					10.00
11.00	Home Health Aide	16,807	77,579					11.00
12.00	Supplies (see instructions)	0	0					12.00
13.00	Drugs	0	0					13.00
14.00	DME	0	0					14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0					15.00
16.00	Respiratory Therapy	0	0					16.00
17.00	Private Duty Nursing	0	0					17.00
18.00	Clinic	0	0					18.00
19.00	Health Promotion Activities	0	0					19.00
20.00	Day Care Program	0	0					20.00
21.00	Home Delivered Meals Program	0	0					21.00
22.00	Homemaker Service	0	0					22.00
23.00	All Others (specify)	0	0					23.00
23.50	Telemedicine	0	0					23.50
24.00	Total (sum of lines 1-23)		3,497,149					24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 14-0213

Period:

Worksheet H-1

HHA CCN: 14-7452

From 10/01/2018

Part II

To 09/30/2019

Date/Time Prepared:

2/26/2020 4:51 am

Home Health
Agency I

PPS

		Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Agency 1 Reconciliation	Administrative & General (ACCUM. COST)		
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)						
		1.00	2.00						3.00
	GENERAL SERVICE COST CENTERS								
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00	
2.00	Capital Related - Movable Equipment		0			0		2.00	
3.00	Plant Operation & Maintenance	0	0	0		0		3.00	
4.00	Transportation (see instructions)	0	0	0	0			4.00	
5.00	Administrative and General	0	0	0	0	- 757,643	2,739,506	5.00	
	HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	0	0	0	0	0	161,697	6.00	
7.00	Physical Therapy	0	0	0	0	0	1,011,157	7.00	
8.00	Occupational Therapy	0	0	0	0	0	0	8.00	
9.00	Speech Pathology	0	0	0	0	0	0	9.00	
10.00	Medical Social Services	0	0	0	0	0	1,505,880	10.00	
11.00	Home Health Aide	0	0	0	0	0	60,772	11.00	
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00	
13.00	Drugs	0	0	0		0	0	13.00	
14.00	DME	0	0	0	0	0	0	14.00	
	HHA NONREIMBURSABLE SERVICES								
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00	
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00	
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00	
18.00	Clinic	0	0	0	0	0	0	18.00	
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00	
20.00	Day Care Program	0	0	0	0	0	0	20.00	
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00	
22.00	Homemaker Service	0	0	0	0	0	0	22.00	
23.00	All Others (specify)	0	0	0	0	0	0	23.00	
23.50	Telemedicine	0	0	0	0	0	0	23.50	
24.00	Total (sum of lines 1-23)	0	0	0	0	- 757,643	2,739,506	24.00	
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		757,643	25.00	
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.276562	26.00	

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0213

Period:

Worksheet H-2

HHA CCN: 14-7452

From 10/01/2018

Part I

To 09/30/2019

Date/Time Prepared:

2/26/2020 4:51 am

Home Health
Agency I

PPS

Cost Center Description		HHA Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
			BLDG & FIXT	MVBLE EQUIP				
		0	1.00	2.00	4.00	4A	5.00	
1.00	Administrative and General	0	0	1,190	583,074	584,264	150,458	1.00
2.00	Skilled Nursing Care	206,416	0	0	0	206,416	53,156	2.00
3.00	Physical Therapy	1,290,805	0	0	0	1,290,805	332,404	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	1,922,349	0	0	0	1,922,349	495,037	6.00
7.00	Home Health Aide	77,579	0	0	0	77,579	19,978	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	3,497,149	0	1,190	583,074	4,081,413	1,051,033	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000		21.00
Cost Center Description		OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		7.00	8.00	9.00	10.00	11.00	13.00	
1.00	Administrative and General	0	0	0	0	0	209,319	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	0	0	0	0	209,319	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0213

Period:

Worksheet H-2

HHA CCN: 14-7452

From 10/01/2018
To 09/30/2019Part I
Date/Time Prepared:
2/26/2020 4:51 am

Cost Center Description		CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	Home Health Agency I PARAMED ED PRGM	Subtotal	
		14.00	15.00	16.00	17.00	23.00	24.00	
1.00	Administrative and General	12,165	0	0	0	0	956,206	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	259,572	2.00
3.00	Physical Therapy	0	0	0	0	0	1,623,209	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	2,417,386	6.00
7.00	Home Health Aide	0	0	0	0	0	97,557	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	12,165	0	0	0	0	5,353,930	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00
Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs			
		25.00	26.00	27.00	28.00			
1.00	Administrative and General	0	956,206					1.00
2.00	Skilled Nursing Care	0	259,572	56,439	316,011			2.00
3.00	Physical Therapy	0	1,623,209	352,938	1,976,147			3.00
4.00	Occupational Therapy	0	0	0	0			4.00
5.00	Speech Pathology	0	0	0	0			5.00
6.00	Medical Social Services	0	2,417,386	525,617	2,943,003			6.00
7.00	Home Health Aide	0	97,557	21,212	118,769			7.00
8.00	Supplies (see instructions)	0	0	0	0			8.00
9.00	Drugs	0	0	0	0			9.00
10.00	DME	0	0	0	0			10.00
11.00	Home Dialysis Aide Services	0	0	0	0			11.00
12.00	Respiratory Therapy	0	0	0	0			12.00
13.00	Private Duty Nursing	0	0	0	0			13.00
14.00	Clinic	0	0	0	0			14.00
15.00	Health Promotion Activities	0	0	0	0			15.00
16.00	Day Care Program	0	0	0	0			16.00
17.00	Home Delivered Meals Program	0	0	0	0			17.00
18.00	Homemaker Service	0	0	0	0			18.00
19.00	All Others (specify)	0	0	0	0			19.00
19.50	Telemedicine	0	0	0	0			19.50
20.00	Total (sum of lines 1-19) (2)	0	5,353,930	956,206	5,353,930			20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.			0.217432				21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-0213

Period:

Worksheet H-2

HHA CCN: 14-7452

From 10/01/2018
To 09/30/2019Part II
Date/Time Prepared:
2/26/2020 4:51 amHome Health
Agency I

PPS

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)					
		1.00	2.00	4.00	5A	5.00	7.00	
1.00	Administrative and General	0	1,193	2,233,648	0	584,264	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	206,416	0	2.00
3.00	Physical Therapy	0	0	0	0	1,290,805	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	1,922,349	0	6.00
7.00	Home Health Aide	0	0	0	0	77,579	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	1,193	2,233,648		4,081,413	0	20.00
21.00	Total cost to be allocated	0	1,190	583,074		1,051,033	0	21.00
22.00	Unit cost multiplier	0.000000	0.997485	0.261041		0.257517	0.000000	22.00
Cost Center Description		LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRS ING)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
		8.00	9.00	10.00	11.00	13.00	14.00	
1.00	Administrative and General	0	0	0	0	50,858	97,747	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	0	0	0	50,858	97,747	20.00
21.00	Total cost to be allocated	0	0	0	0	209,319	12,165	21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.000000	0.000000	4.115754	0.124454	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-0213

Period:

Worksheet H-2

HHA CCN: 14-7452

From 10/01/2018
To 09/30/2019Part II
Date/Time Prepared:
2/26/2020 4:51 amHome Health
Agency I

PPS

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

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0213

Period:

Worksheet H-3

HHA CCN: 14-7452

From 10/01/2018
To 09/30/2019Part I
Date/Time Prepared:
2/26/2020 4:51 am

				Title XVIII		Home Health Agency I	2/26/2020 4:31 am PPS		
Cost Center Description		From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)		
		0	1.00	2.00	3.00	4.00	5.00		
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION									
Cost Per Visit Computation									
1.00	Skilled Nursing Care	2.00	316,011		316,011	11,948	26.45	1.00	
2.00	Physical Therapy	3.00	1,976,147	469,874	2,446,021	8,557	285.85	2.00	
3.00	Occupational Therapy	4.00	0	212,171	212,171	3,188	66.55	3.00	
4.00	Speech Pathology	5.00	0	0	0	360	0.00	4.00	
5.00	Medical Social Services	6.00	2,943,003		2,943,003	106	27,764.18	5.00	
6.00	Home Health Aide	7.00	118,769		118,769	1,387	85.63	6.00	
7.00	Total (sum of lines 1-6)		5,353,930	682,045	6,035,975	25,546		7.00	
Cost Center Description		Cost Limits	CBSA No. (1)	Part A	Program Visits				
					Part B				
					Not Subject to Deductibles & Coinsurance	Subject to Deductibles			
		0	1.00	2.00	3.00	4.00	5.00		
Limitation Cost Computation									
8.00	Skilled Nursing Care		16974	0	7,948			8.00	
9.00	Physical Therapy		16974	0	5,569			9.00	
10.00	Occupational Therapy		16974	0	2,129			10.00	
11.00	Speech Pathology		16974	0	260			11.00	
12.00	Medical Social Services		16974	0	81			12.00	
13.00	Home Health Aide		16974	0	1,096			13.00	
14.00	Total (sum of lines 8-13)			0	17,083			14.00	
Cost Center Description		From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)		
		0	1.00	2.00	3.00	4.00	5.00		
Supplies and Drugs Cost Computations									
15.00	Cost of Medical Supplies	8.00	0	4,999	4,999	18,485	0.270435	15.00	
16.00	Cost of Drugs	9.00	0	64	64	182	0.351648	16.00	
Cost Center Description		Part A	Program Visits		Cost of Services				
			Part B						
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		
			6.00	7.00	8.00	9.00	10.00	11.00	
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION									
Cost Per Visit Computation									
1.00	Skilled Nursing Care	0	7,948		0	210,225		1.00	
2.00	Physical Therapy	0	5,569		0	1,591,899		2.00	
3.00	Occupational Therapy	0	2,129		0	141,685		3.00	
4.00	Speech Pathology	0	260		0	0		4.00	
5.00	Medical Social Services	0	81		0	2,248,899		5.00	
6.00	Home Health Aide	0	1,096		0	93,850		6.00	
7.00	Total (sum of lines 1-6)	0	17,083		0	4,286,558		7.00	
Cost Center Description									
		6.00	7.00	8.00	9.00	10.00	11.00		
Limitation Cost Computation									
8.00	Skilled Nursing Care							8.00	
9.00	Physical Therapy							9.00	
10.00	Occupational Therapy							10.00	
11.00	Speech Pathology							11.00	
12.00	Medical Social Services							12.00	
13.00	Home Health Aide							13.00	
14.00	Total (sum of lines 8-13)							14.00	

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0213

Period:

Worksheet H-3

HHA CCN: 14-7452

From 10/01/2018
To 09/30/2019Part I
Date/Time Prepared:
2/26/2020 4:51 am

Title XVIII

Home Health
Agency I

PPS

Cost Center Description		Program Covered Charges		Cost of Services	Agency 1			
		Part A	Part B		Part A	Part B		
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
			6.00	7.00		8.00	9.00	10.00
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	0	13,178	0	0	3,564	0	15.00
16.00	Cost of Drugs		0	0		0	0	16.00
Cost Center Description		Total Program Cost (sum of cols. 9-10)						
		12.00						
		PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION						
Cost Per Visit Computation								
1.00	Skilled Nursing Care	210,225						1.00
2.00	Physical Therapy	1,591,899						2.00
3.00	Occupational Therapy	141,685						3.00
4.00	Speech Pathology	0						4.00
5.00	Medical Social Services	2,248,899						5.00
6.00	Home Health Aide	93,850						6.00
7.00	Total (sum of lines 1-6)	4,286,558						7.00
Cost Center Description								
		12.00						
Limitation Cost Computation								
8.00	Skilled Nursing Care							8.00
9.00	Physical Therapy							9.00
10.00	Occupational Therapy							10.00
11.00	Speech Pathology							11.00
12.00	Medical Social Services							12.00
13.00	Home Health Aide							13.00
14.00	Total (sum of lines 8-13)							14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0213

Period:

Worksheet H-3

HHA CCN: 14-7452

From 10/01/2018
To 09/30/2019Part II
Date/Time Prepared:
2/26/2020 4:51 am

Title XVIII

Home Health
Agency I

PPS

Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
	0	1.00	2.00	3.00	4.00		
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00 Physical Therapy	66.00	0.243897	1,926,526	469,874	col. 2, line 2.00		1.00
2.00 Occupational Therapy	67.00	0.301264	704,270	212,171	col. 2, line 3.00		2.00
3.00 Speech Pathology	68.00	0.000000	82,919	0	col. 2, line 4.00		3.00
4.00 Cost of Medical Supplies	71.00	0.270455	18,485	4,999	col. 2, line 15.00		4.00
5.00 Cost of Drugs	73.00	0.352866	182	64	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0213 HHA CCN: 14-7452	Period: From 10/01/2018 To 09/30/2019	Worksheet H-4 Part I-II Date/Time Prepared: 2/26/2020 4:51 am	
		Title XVIII	Home Health Agency I	PPS	
		Part A	Part B		
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		1.00	2.00	3.00	
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES					
Reasonable Cost of Part A & Part B Services					
1.00	Reasonable cost of services (see instructions)	0	0	0	1.00
2.00	Total charges	0	0	0	2.00
Customary Charges					
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	3.00
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(b)	0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	0	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00
9.00	Primary payer amounts	0	0	0	9.00
			Part A Services	Part B Services	
			1.00	2.00	
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT					
10.00	Total reasonable cost (see instructions)		0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers		0	2,791,890	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers		0	193,130	12.00
13.00	Total PPS Reimbursement - LUPA Episodes		0	46,354	13.00
14.00	Total PPS Reimbursement - PEP Episodes		0	61,036	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		0	28,707	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	11,548	16.00
17.00	Total Other Payments		0	0	17.00
18.00	DME Payments		0	0	18.00
19.00	Oxygen Payments		0	0	19.00
20.00	Prosthetic and Orthotic Payments		0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		0	3,132,665	22.00
23.00	Excess reasonable cost (from line 8)		0	0	23.00
24.00	Subtotal (line 22 minus line 23)		0	3,132,665	24.00
25.00	Coinsurance billed to program patients (from your records)		0	0	25.00
26.00	Net cost (line 24 minus line 25)		0	3,132,665	26.00
27.00	Reimbursable bad debts (from your records)				27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)				28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)		0	3,132,665	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	0	30.50
30.99	Demonstration payment adjustment amount before sequestration		0	0	30.99
31.00	Subtotal (see instructions)		0	3,132,665	31.00
31.01	Sequestration adjustment (see instructions)		0	62,653	31.01
31.02	Demonstration payment adjustment amount after sequestration		0	0	31.02
32.00	Interim payments (see instructions)		0	3,070,012	32.00
33.00	Tentative settlement (for contractor use only)		0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)		0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0	35.00

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

Provider CCN: 14-0213

Period:

Worksheet H-5

HHA CCN: 14-7452

From 10/01/2018
To 09/30/2019Date/Time Prepared:
2/26/2020 4:51 amHome Health
Agency I

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0			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		3,070,012	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		3,070,012	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		3,070,012	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0213	Period: From 10/01/2018 To 09/30/2019	Worksheet L Parts I-III Date/Time Prepared: 2/26/2020 4:51 am
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		5,125,214	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		60,282	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)		187.84	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		1.84	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		14.87	8.00
9.00	Sum of lines 7 and 8		16.71	9.00
10.00	Allowable disproportionate share percentage (see instructions)		3.44	10.00
11.00	Disproportionate share adjustment (see instructions)		176,307	11.00
12.00	Total prospective capital payments (see instructions)		5,361,803	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