

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: 14-0008	Period: From 07/01/2019 To 06/30/2020	Worksheet S Parts I-III Date/Time Prepared: 1/28/2021 3:56 pm
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 1/28/2021	Time: 3:56 pm
	2. ☐ Manually prepared cost report		
	3. ☐ If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. ☐ Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. ☐ Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. ☐ Initial Report for this Provider CCN 9. ☐ Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. ☐ If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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 GOTTLIEB MEMORIAL HOSPITAL (14-0008) for the cost reporting period beginning 07/01/2019 and ending 06/30/2020 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed)

Officer or Administrator of Provider(s)

Title

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	278,469	-15,823	0	0	1.00
2.00	Subprovider - IPF	0	29,818	0		0	2.00
3.00	Subprovider - IRF	0	44,715	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	6,998	0		0	7.00
200.00	Total	0	360,000	-15,823	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: 14-0008	Period: From 07/01/2019 To 06/30/2020	Worksheet S-2 Part I Date/Time Prepared: 1/28/2021 3:56 pm
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	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 8700 WEST NORTH AVENUE	PO Box:			1.00
2.00	City: MELROSE PARK	State: IL	Zip Code: 60160	County:	2.00

	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
						V	XVIII	XIX	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	

	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	GOTTLIEB MEMORIAL HOSPITAL	140008	99914	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF	GOTTLIEB MEMORIAL PSYCHIATRIC UNIT	14S008	99914	4	01/01/2007	N	P	N	4.00
5.00	Subprovider - IRF	GOTTLIEB MEMORIAL REHABILITATION UNI	14T008	99914	5	07/01/1999	N	P	O	5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF	GOTTLIEB SKILLED NURSING CARE	145526	99914		06/10/1985	N	P	N	9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
17.10	Hospital-Based (CORF) I									17.10
17.20	Hospital-Based (OPT) I									17.20
17.30	Hospital-Based (OOT) I									17.30
17.40	Hospital-Based (OSP) I									17.40
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	07/01/2019	06/30/2020	20.00
21.00	Type of Control (see instructions)	2		21.00
		1.00	2.00	3.00

Inpatient PPS Information		1100	1100	0100	
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	Y	Y		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	1	N		23.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0008

Period:
From 07/01/2019
To 06/30/2020Worksheet S-2
Part I
Date/Time Prepared:
1/28/2021 3:56 pm

	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
	1.00	2.00	3.00	4.00	5.00	6.00	
24.00 If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	870	620	1	10	1,883	0	24.00
25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	141	148	0	0	363		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.					2		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.					2		27.00
35.00 If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00
					Beginning:	Ending:	
					1.00	2.00	
36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00
37.00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00
37.01 Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)							37.01
38.00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00
					Y/N	Y/N	
					1.00	2.00	
39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00
40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N	40.00
					V	XVIII	XIX
					1.00	2.00	3.00
Prospective Payment System (PPS)-Capital							
45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	N	N
46.00 Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N
47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y" for yes or "N" for no.					N	N	N
48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N
Teaching Hospitals							
56.00 Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA GME payment reduction? Enter "Y" for yes or "N" for no in column 2.					Y	Y	
57.00 If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					N		
58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N		
59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0008		Period: From 07/01/2019 To 06/30/2020		Worksheet S-2 Part I Date/Time Prepared: 1/28/2021 3:56 pm	
		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code			
		1.00	2.00	3.00			
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.	N				60.00	
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)					61.01	
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)					61.02	
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)					61.03	
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).					61.04	
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)					61.05	
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)					61.06	
		Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00		2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	
61.20	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	
						1.00	
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 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	
62.01	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	
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	
		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	0.00	0.000000		64.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0008

Period:
From 07/01/2019
To 06/30/2020Worksheet S-2
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Date/Time Prepared:
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	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		
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))			
			1.00	2.00	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	N	0	71.00
Inpatient Rehabilitation Facility PPS								
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				Y		75.00	
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				N	N	0	76.00

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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)			106.00	
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)			107.00	
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
				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: 14-0008	Period: From 07/01/2019 To 06/30/2020	Worksheet S-2 Part I Date/Time Prepared: 1/28/2021 3:56 pm
		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00
		1.00	2.00	3.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112.00
Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	Y		116.00
117.00	Is this facility legally required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1		118.00
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	3,254,910	0	0118.01
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	902022	140.00

Health Financial Systems		GOTTlieb MEMORIAL HOSPITAL		In Lieu of Form CMS-2552-10	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA			Provider CCN: 14-0008		Period: From 07/01/2019 To 06/30/2020
			Worksheet S-2 Part I Date/Time Prepared: 1/28/2021 3:56 pm		
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: TRINITY HEALTH HOME OFFICE	Contractor's Name: WISCONSIN PHYSICIANS SERVICE		Contractor's Number: 08201	
142.00	Street: 20555 VICTORY PARKWAY	PO Box:			
143.00	City: LIVONIA	State: MI		Zip Code: 48152	
					1.00
144.00 Are provider based physicians' costs included in Worksheet A?					Y
					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.				N
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.				
					1.00
147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.					Y
148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.					N
149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.					N
		Part A 1.00	Part B 2.00	Title V 3.00	Title XIX 4.00
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N
156.00	Subprovider - IPF	N	N	N	N
157.00	Subprovider - IRF	N	N	N	N
158.00	SUBPROVIDER				
159.00	SNF	N	N	N	N
160.00	HOME HEALTH AGENCY	N	N	N	N
161.00	CMHC		N	N	N
161.10	CORF		N	N	N
161.20	OUTPATIENT PHYSICAL THERAPY		N	N	N
161.30	OUTPATIENT OCCUPATIONAL THERAPY		N	N	N
161.40	OUTPATIENT SPEECH PATHOLOGY		N	N	N
					1.00
Multicampus					
165.00 Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.					N
		Name 0	County 1.00	State 2.00	Zip Code 3.00
					CBSA 4.00
					FTE/Campus 5.00
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)				0.00
					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
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)					
168.01 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)					
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
				Beginning 1.00	Ending 2.00
170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)					

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-0008	Period: From 07/01/2019 To 06/30/2020	Worksheet S-2 Part I Date/Time Prepared: 1/28/2021 3:56 pm
		1.00	2.00
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0008	Period: From 07/01/2019 To 06/30/2020	Worksheet S-2 Part II Date/Time Prepared: 1/28/2021 3:56 pm
			Y/N 1.00	Date 2.00
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.				
COMPLETED BY ALL HOSPITALS				
Provider Organization and Operation				
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00
		Y/N 1.00	Date 2.00	V/I 3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y		3.00
		Y/N 1.00	Type 2.00	Date 3.00
Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	09/30/2017
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.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	Y		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00
			Y/N 1.00	
Bad Debts				
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.		Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.		N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.		N	14.00
Bed Complement				
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.		N	15.00
		Part A		Part B
		Y/N 1.00	Date 2.00	Y/N 3.00
				Date 4.00
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	11/08/2017	Y
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0008

Period:
From 07/01/2019
To 06/30/2020Worksheet S-2
Part II
Date/Time Prepared:
1/28/2021 3:56 pm

		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?				36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DAVID	PALUCK		41.00
42.00	Enter the employer/company name of the cost report preparer.	LOYOLA UNIVERSITY HEALTH SYSTEM			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	708-216-6719	DAVID.PALUCK@TRINITY-HEALTH.ORG		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0008

Period:
From 07/01/2019
To 06/30/2020Worksheet S-2
Part II
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		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REGIONAL DIRECTOR OF REIMBURSEMENT	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0008

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part I
Date/Time Prepared:
1/28/2021 3:56 pm

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	119	43,554	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)		119	43,554	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	16	5,856	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)		135	49,410	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	12	4,392		0	16.00
17.00 SUBPROVIDER - IRF	41.00	20	7,320		0	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	44.00	34	12,444		0	19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	99.10				0	25.10
25.20 CMHC - OUTPATIENT PHYSICAL THERAPY	99.20				0	25.20
25.30 CMHC - OUTPATIENT OCCUPATIONAL THERAPY	99.30				0	25.30
25.40 CMHC - OUTPATIENT SPEECH PATHOLOGY	99.40				0	25.40
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		201				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: 14-0008

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part I
Date/Time Prepared:
1/28/2021 3:56 pm

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	8,964	733	19,324			1.00
2.00	HMO and other (see instructions)	4,940	2,513				2.00
3.00	HMO IPF Subprovider	48	0				3.00
4.00	HMO IRF Subprovider	693	511				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)	8,964	733	19,324			7.00
8.00	INTENSIVE CARE UNIT	1,296	138	3,649			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		0	0			13.00
14.00	Total (see instructions)	10,260	871	22,973	3.89	626.93	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	2,789	0	2,981	0.00	16.26	16.00
17.00	SUBPROVIDER - IRF	2,688	141	5,157	0.00	25.06	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	4,931	238	7,095	0.00	31.40	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	0	0	0	0.00	0.00	25.10
25.20	CMHC - OUTPATIENT PHYSICAL THERAPY	0	0	0	0.00	0.00	25.20
25.30	CMHC - OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0.00	0.00	25.30
25.40	CMHC - OUTPATIENT SPEECH PATHOLOGY	0	0	0	0.00	0.00	25.40
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				3.89	699.65	27.00
28.00	Observation Bed Days		442	2,745			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			109			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			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: 14-0008

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part I
Date/Time Prepared:
1/28/2021 3:56 pm

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	2,144	667	4,882	1.00
2.00 HMO and other (see instructions)			938	0		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	2,144	667	4,882	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	193	0	202	16.00
17.00 SUBPROVIDER - IRF	0.00	0	208	39	390	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	0.00					19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	0.00					25.10
25.20 CMHC - OUTPATIENT PHYSICAL THERAPY	0.00					25.20
25.30 CMHC - OUTPATIENT OCCUPATIONAL THERAPY	0.00					25.30
25.40 CMHC - OUTPATIENT SPEECH PATHOLOGY	0.00					25.40
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0008

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part II
Date/Time Prepared:
1/28/2021 3:56 pm

	Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	45,802,480	0	45,802,480	1,455,281.42	31.47
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	1,972,687	0	1,972,687	65,318.56	30.20
10.00	Excluded area salaries (see instructions)		3,392,248	0	3,392,248	101,907.41	33.29
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		1,728,346	0	1,728,346	31,324.00	55.18
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		3,585,082	0	3,585,082	75,563.00	47.44
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
16.01	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00
16.02	Home office contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		8,729,842	0	8,729,842		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		1,144,028	0	1,144,028		
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)		998,282	0	998,282		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0008

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part II
Date/Time Prepared:
1/28/2021 3:56 pm

		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.53	Home office: Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	445,037	0	445,037	19,509.48	22.81	26.00
27.00	Administrative & General	5.00	2,937,637	-103,842	2,833,795	120,657.27	23.49	27.00
28.00	Administrative & General under contract (see inst.)		570,392	0	570,392	6,190.00	92.15	28.00
29.00	Maintenance & Repairs	6.00	863,501	0	863,501	26,711.28	32.33	29.00
30.00	Operation of Plant	7.00	751,786	0	751,786	37,982.12	19.79	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	1,343,365	0	1,343,365	85,438.67	15.72	32.00
33.00	Housekeeping under contract (see instructions)		98,998	0	98,998	3,993.00	24.79	33.00
34.00	Dietary	10.00	1,164,581	-759,954	404,627	23,555.13	17.18	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	759,954	759,954	44,240.38	17.18	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,173,560	103,842	1,277,402	23,633.32	54.05	38.00
39.00	Central Services and Supply	14.00	1,037,850	0	1,037,850	45,673.52	22.72	39.00
40.00	Pharmacy	15.00	1,992,897	0	1,992,897	45,898.08	43.42	40.00
41.00	Medical Records & Medical Records Library	16.00	0	0	0	1,818.50	0.00	41.00
42.00	Social Service	17.00	541,321	0	541,321	15,706.82	34.46	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0008

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part III
Date/Time Prepared:
1/28/2021 3:56 pm

	Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	46,471,870	0	46,471,870	1,465,464.42	31.71	1.00
2.00	Excluded area salaries (see instructions)	5,364,935	0	5,364,935	167,225.97	32.08	2.00
3.00	Subtotal salaries (line 1 minus line 2)	41,106,935	0	41,106,935	1,298,238.45	31.66	3.00
4.00	Subtotal other wages & related costs (see inst.)	5,313,428	0	5,313,428	106,887.00	49.71	4.00
5.00	Subtotal wage-related costs (see inst.)	9,728,124	0	9,728,124	0.00	23.67	5.00
6.00	Total (sum of lines 3 thru 5)	56,148,487	0	56,148,487	1,405,125.45	39.96	6.00
7.00	Total overhead cost (see instructions)	12,920,925	0	12,920,925	501,007.57	25.79	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 14-0008

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part IV
Date/Time Prepared:
1/28/2021 3:56 pm

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	935,826	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	74,673	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)	3,624,138	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	224,380	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	81,355	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)	313,121	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	948,536	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	2,723,546	17.00
18.00	Medicare Taxes - Employers Portion Only	636,958	18.00
19.00	Unemployment Insurance	281,000	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	30,338	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	9,873,871	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: 14-0008

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

 Worksheet S-3
 Part V
 Date/Time Prepared:
 1/28/2021 3:56 pm

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	1,728,346	9,873,871	1.00
2.00	Hospital	1,728,346	9,873,871	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			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
16.10	Hospital-Based-CMHC 10	0	0	16.10
16.20	Hospital-Based-CMHC 20	0	0	16.20
16.30	Hospital-Based-CMHC 30	0	0	16.30
16.40	Hospital-Based-CMHC 40	0	0	16.40
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 14-0008

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

Worksheet S-10

Date/Time Prepared:
1/28/2021 3:56 pm

			1.00	
Uncompensated and indigent care cost computation				
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.190332	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		14,807,165	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?			3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?			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		88,526,594	6.00
7.00	Medicaid cost (line 1 times line 6)		16,849,444	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)		2,042,279	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)		2,042,279	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)	13,495,206	78,777	13,573,983
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	2,568,570	78,777	2,647,347
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0
23.00	Cost of charity care (line 21 minus line 22)	2,568,570	78,777	2,647,347
			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)		13,418,642	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		545,406	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		839,087	27.01
28.00	Non-Medicare bad debt expense (see instructions)		12,579,555	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		2,687,973	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		5,335,320	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		7,377,599	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0008

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

Worksheet A

Date/Time Prepared:
1/28/2021 3:56 pm

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		9,441,666	9,441,666	-2,861,401	6,580,265	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	3,479,533	3,479,533	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	445,037	114,295	559,332	-5,268	554,064	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,937,637	26,909,204	29,846,841	-1,058,911	28,787,930	5.00
6.00	00600	MAINTENANCE & REPAIRS	863,501	1,831,382	2,694,883	-3,070	2,691,813	6.00
7.00	00700	OPERATION OF PLANT	751,786	3,612,497	4,364,283	-21,946	4,342,337	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	-66	-66	107,198	107,132	8.00
9.00	00900	HOUSEKEEPING	1,343,365	2,191,049	3,534,414	-16,416	3,517,998	9.00
10.00	01000	DIETARY	1,164,581	837,753	2,002,334	-1,313,814	688,520	10.00
11.00	01100	CAFETERIA	0	-6	-6	1,293,152	1,293,146	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	1,173,560	241,220	1,414,780	123,103	1,537,883	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,037,850	456,385	1,494,235	-14,968	1,479,267	14.00
15.00	01500	PHARMACY	1,992,897	3,336,020	5,328,917	-1,426,381	3,902,536	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	541,321	169,087	710,408	-14	710,394	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	328,980	328,980	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	8,250,621	2,533,228	10,783,849	-419,356	10,364,493	30.00
31.00	03100	INTENSIVE CARE UNIT	2,964,351	1,170,459	4,134,810	-283,295	3,851,515	31.00
40.00	04000	SUBPROVIDER - IPF	1,060,476	355,502	1,415,978	-10,725	1,405,253	40.00
41.00	04100	SUBPROVIDER - IRF	1,796,839	554,612	2,351,451	-74,991	2,276,460	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	1,972,687	1,195,405	3,168,092	-87,745	3,080,347	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,926,036	8,460,810	10,386,846	-4,812,553	5,574,293	50.00
51.00	05100	RECOVERY ROOM	413,394	109,313	522,707	-10,350	512,357	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	481,635	481,635	-113,815	367,820	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,607,360	412,435	2,019,795	-23,077	1,996,718	54.00
56.00	05600	RADIOISOTOPE	163,913	223,414	387,327	-57,389	329,938	56.00
56.01	03630	ULTRASOUND	486,004	115,406	601,410	-32,527	568,883	56.01
57.00	05700	CT SCAN	474,407	200,168	674,575	-17,811	656,764	57.00
58.00	05800	MRI	163,080	86,615	249,695	-31,749	217,946	58.00
59.00	05900	CARDIAC CATHETERIZATION	611,262	1,383,611	1,994,873	-968,824	1,026,049	59.00
60.00	06000	LABORATORY	2,152,968	3,147,992	5,300,960	404,947	5,705,907	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,147,529	548,242	1,695,771	-55,069	1,640,702	65.00
66.00	06600	PHYSICAL THERAPY	1,980,280	348,771	2,329,051	-13,372	2,315,679	66.00
67.00	06700	OCCUPATIONAL THERAPY	277,975	43,232	321,207	-711	320,496	67.00
68.00	06800	SPEECH PATHOLOGY	193,546	102,322	295,868	-60,449	235,419	68.00
69.00	06900	ELECTROCARDIOLOGY	355,481	196,860	552,341	-19,337	533,004	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	88,730	59,656	148,386	-28,118	120,268	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	4,644,580	4,644,580	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	4,696,984	4,696,984	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	857,384	857,384	73.00
73.01	07301	OUTPATIENT PHARMACY	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	LITHOTRIPSY	0	0	0	0	0	76.00
76.01	03951	CARDIAC REHABILITATION	144,669	27,249	171,918	-2,946	168,972	76.01
76.02	03020	GASTROINTESTINAL SERVICES	757,645	817,890	1,575,535	-355,652	1,219,883	76.02
76.03	03030	ANGIOCARDIOGRAPHY	0	0	0	0	0	76.03
76.05	03954	INPATIENT RENAL DIALYSIS	0	0	0	0	0	76.05
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	794,379	185,508	979,887	-979,887	0	90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES	0	0	0	0	0	90.01
90.02	04950	WOUND CARE	17,133	1,127,456	1,144,589	-394,125	750,464	90.02
90.03	09003	RIVER FOREST	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	3,215,247	1,711,464	4,926,711	-359,799	4,566,912	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0008

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

Worksheet A

Date/Time Prepared:
1/28/2021 3:56 pm

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	45,267,547	74,739,741	120,007,288	0	120,007,288	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	23,334	54,207	77,541	0	77,541	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	NON-EMPLOYEE CHILD CARE CENTER	0	0	0	0	0	192.01
192.02	19202	OUTPATIENT PHARMACY	388,201	1,318,246	1,706,447	0	1,706,447	192.02
192.03	19203	WEST TOWN PHO	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	16,282	16,282	0	16,282	193.00
193.01	19301	ADULT DAY CARE	123,398	36,149	159,547	0	159,547	193.01
194.00	07950	DISCONTINUED HOME HEALTH AND HOSPICE	0	0	0	0	0	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	45,802,480	76,164,625	121,967,105	0	121,967,105	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0008

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

Worksheet A

Date/Time Prepared:
1/28/2021 3:56 pm

Cost Center Description			Adjustments (See A-8) 6.00	Net Expenses For Allocation 7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-229,032	6,351,233	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	3,479,533	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-394,913	159,151	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-5,444,615	23,343,315	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	2,691,813	6.00
7.00	00700	OPERATION OF PLANT	0	4,342,337	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	107,132	8.00
9.00	00900	HOUSEKEEPING	0	3,517,998	9.00
10.00	01000	DIETARY	-156,957	531,563	10.00
11.00	01100	CAFETERIA	0	1,293,146	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	1,537,883	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,479,267	14.00
15.00	01500	PHARMACY	0	3,902,536	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	16.00
17.00	01700	SOCIAL SERVICE	-330,509	379,885	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	328,980	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	10,364,493	30.00
31.00	03100	INTENSIVE CARE UNIT	0	3,851,515	31.00
40.00	04000	SUBPROVIDER - IPF	-153,600	1,251,653	40.00
41.00	04100	SUBPROVIDER - IRF	-5,000	2,271,460	41.00
43.00	04300	NURSERY	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	3,080,347	44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-168,865	5,405,428	50.00
51.00	05100	RECOVERY ROOM	0	512,357	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	-162,502	205,318	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,996,718	54.00
56.00	05600	RADIOISOTOPE	0	329,938	56.00
56.01	03630	ULTRASOUND	0	568,883	56.01
57.00	05700	CT SCAN	0	656,764	57.00
58.00	05800	MRI	0	217,946	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,026,049	59.00
60.00	06000	LABORATORY	-1,725,636	3,980,271	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	1,640,702	65.00
66.00	06600	PHYSICAL THERAPY	0	2,315,679	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	320,496	67.00
68.00	06800	SPEECH PATHOLOGY	0	235,419	68.00
69.00	06900	ELECTROCARDIOLOGY	0	533,004	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	120,268	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	4,644,580	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	4,696,984	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	857,384	73.00
73.01	07301	OUTPATIENT PHARMACY	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03950	LITHOTRIPSY	0	0	76.00
76.01	03951	CARDIAC REHABILITATION	0	168,972	76.01
76.02	03020	GASTROINTESTINAL SERVICES	0	1,219,883	76.02
76.03	03030	ANGIOCARDIOGRAPHY	0	0	76.03
76.05	03954	INPATIENT RENAL DIALYSIS	0	0	76.05
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES	0	0	90.01
90.02	04950	WOUND CARE	0	750,464	90.02
90.03	09003	RIVER FOREST	0	0	90.03
91.00	09100	EMERGENCY	-125,000	4,441,912	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	99.40

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0008

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

Worksheet A

Date/Time Prepared:
1/28/2021 3:56 pm

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-8,896,629	111,110,659	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	77,541	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
192.01	19201	NON-EMPLOYEE CHILD CARE CENTER	0	0	192.01
192.02	19202	OUTPATIENT PHARMACY	0	1,706,447	192.02
192.03	19203	WEST TOWN PHO	0	0	192.03
193.00	19300	NONPAID WORKERS	0	16,282	193.00
193.01	19301	ADULT DAY CARE	0	159,547	193.01
194.00	07950	DISCONTINUED HOME HEALTH AND HOSPICE	0	0	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-8,896,629	113,070,476	200.00

RECLASSIFICATIONS

Provider CCN: 14-0008

Period:
From 07/01/2019
To 06/30/2020Worksheet A-6
Date/Time Prepared:
1/28/2021 3:56 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - Drugs Charged to Patients					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,112,453		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12.00		0.00	0	0		12.00
13.00		0.00	0	0		13.00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
25.00		0.00	0	0		25.00
26.00		0.00	0	0		26.00
27.00		0.00	0	0		27.00
28.00		0.00	0	0		28.00
			0	1,112,453		
	C - Dietary Shared Cost					
1.00	CAFETERIA	11.00	759,954	546,681		1.00
			759,954	546,681		
	E - Interns and Residents					
1.00	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	0	328,980		1.00
			0	328,980		
	F - Blood Transfusion					
1.00	LABORATORY	60.00	0	750,586		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
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
			0	750,586		
	I - Medical Supplies Charged to Patients					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	4,670,524		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
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

RECLASSIFICATIONS

Provider CCN: 14-0008

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

Worksheet A-6

Date/Time Prepared:
1/28/2021 3:56 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15.00
16.00		0.00	0	0		16.00
17.00		0.00	0	0		17.00
18.00		0.00	0	0		18.00
19.00		0.00	0	0		19.00
20.00		0.00	0	0		20.00
21.00		0.00	0	0		21.00
22.00		0.00	0	0		22.00
23.00		0.00	0	0		23.00
24.00		0.00	0	0		24.00
25.00		0.00	0	0		25.00
26.00		0.00	0	0		26.00
0			0	4,670,524		
L - Implantable Devices						
1.00	INTENSIVE CARE UNIT	31.00	0	54		1.00
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	4,696,989		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
0			0	4,697,043		
N - Capital Movable Equipment						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	3,479,533		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
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
0			0	3,479,533		
O - Interest Expense						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	590,100		1.00
0			0	590,100		
P - Nursing Admin						
1.00	NURSING ADMINISTRATION	13.00	103,842	20,505		1.00
			103,842	20,505		
Q - Laundry Depart Return						
1.00	LAUNDRY & LINEN SERVICE	8.00	0	107,198		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
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

RECLASSIFICATIONS

Provider CCN: 14-0008

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

Worksheet A-6

Date/Time Prepared:
1/28/2021 3:56 pm

Increases					
Cost Center	Line #	Salary	Other		
2.00	3.00	4.00	5.00		
TOTALS		0	107,198		
R - Same Day Surgery					
1.00	OPERATING ROOM	50.00	794,379	185,508	1.00
2.00					2.00
3.00					3.00
4.00					4.00
5.00					5.00
		794,379	185,508		
500.00	Grand Total: Increases	1,658,175	16,489,111		500.00

RECLASSIFICATIONS

Provider CCN: 14-0008

Period:
From 07/01/2019
To 06/30/2020Worksheet A-6
Date/Time Prepared:
1/28/2021 3:56 pm

		Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.			
	6.00	7.00	8.00	9.00	10.00			
	A - Drugs Charged to Patients							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	3,461	0		1.00	
2.00	HOUSEKEEPING	9.00	0	5	0		2.00	
3.00	NURSING ADMINISTRATION	13.00	0	47	0		3.00	
4.00	CENTRAL SERVICES & SUPPLY	14.00	0	644	0		4.00	
5.00	PHARMACY	15.00	0	941,198	0		5.00	
6.00	ADULTS & PEDIATRICS	30.00	0	36,675	0		6.00	
7.00	INTENSIVE CARE UNIT	31.00	0	17,231	0		7.00	
8.00	SUBPROVIDER - IPF	40.00	0	97	0		8.00	
9.00	SUBPROVIDER - IRF	41.00	0	1,335	0		9.00	
10.00	SKILLED NURSING FACILITY	44.00	0	2,876	0		10.00	
11.00	OPERATING ROOM	50.00	0	16,414	0		11.00	
12.00	RECOVERY ROOM	51.00	0	1,009	0		12.00	
13.00	ANESTHESIOLOGY	53.00	0	20,559	0		13.00	
14.00	RADIOLOGY-DIAGNOSTIC	54.00	0	587	0		14.00	
15.00	RADIOISOTOPE	56.00	0	598	0		15.00	
16.00	ULTRASOUND	56.01	0	92	0		16.00	
17.00	CT SCAN	57.00	0	1,680	0		17.00	
18.00	MRI	58.00	0	9,422	0		18.00	
19.00	CARDIAC CATHETERIZATION	59.00	0	1,776	0		19.00	
20.00	LABORATORY	60.00	0	75	0		20.00	
21.00	RESPIRATORY THERAPY	65.00	0	1,225	0		21.00	
22.00	PHYSICAL THERAPY	66.00	0	51	0		22.00	
23.00	ELECTROCARDIOLOGY	69.00	0	1,316	0		23.00	
24.00	ELECTROENCEPHALOGRAPHY	70.00	0	81	0		24.00	
25.00	GASTROINTESTINAL SERVICES	76.02	0	7,322	0		25.00	
26.00	CLINIC	90.00	0	7,381	0		26.00	
27.00	WOUND CARE	90.02	0	92	0		27.00	
28.00	EMERGENCY	91.00	0	39,204	0		28.00	
			0	1,112,453				
	C - Dietary Shared Cost							
1.00	DIETARY	10.00	759,954	546,681	0		1.00	
			759,954	546,681				
	E - Interns and Residents							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	328,980	0		1.00	
			0	328,980				
	F - Blood Transfusion							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1,807	0		1.00	
2.00	HOUSEKEEPING	9.00	0	3	0		2.00	
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	1	0		3.00	
4.00	PHARMACY	15.00	0	484,473	0		4.00	
5.00	ADULTS & PEDIATRICS	30.00	0	179	0		5.00	
6.00	INTENSIVE CARE UNIT	31.00	0	12	0		6.00	
7.00	SUBPROVIDER - IPF	40.00	0	21	0		7.00	
8.00	SUBPROVIDER - IRF	41.00	0	2	0		8.00	
9.00	SKILLED NURSING FACILITY	44.00	0	20	0		9.00	
10.00	OPERATING ROOM	50.00	0	1,511	0		10.00	
11.00	ANESTHESIOLOGY	53.00	0	5,200	0		11.00	
12.00	RADIOLOGY-DIAGNOSTIC	54.00	0	258	0		12.00	
13.00	ULTRASOUND	56.01	0	21	0		13.00	
14.00	MRI	58.00	0	4,533	0		14.00	
15.00	CARDIAC CATHETERIZATION	59.00	0	4	0		15.00	
16.00	PHYSICAL THERAPY	66.00	0	26	0		16.00	
17.00	DRUGS CHARGED TO PATIENTS	73.00	0	247,693	0		17.00	
18.00	CLINIC	90.00	0	10	0		18.00	
19.00	WOUND CARE	90.02	0	48	0		19.00	
20.00	EMERGENCY	91.00	0	4,764	0		20.00	
			0	750,586				
	I - Medical Supplies Charged to Patients							
1.00	ADULTS & PEDIATRICS	30.00	0	382,075	0		1.00	
2.00	INTENSIVE CARE UNIT	31.00	0	226,508	0		2.00	
3.00	SUBPROVIDER - IPF	40.00	0	9,764	0		3.00	
4.00	SUBPROVIDER - IRF	41.00	0	73,349	0		4.00	
5.00	SKILLED NURSING FACILITY	44.00	0	84,844	0		5.00	
6.00	OPERATING ROOM	50.00	0	1,826,313	0		6.00	
7.00	RECOVERY ROOM	51.00	0	9,336	0		7.00	
8.00	ANESTHESIOLOGY	53.00	0	88,056	0		8.00	
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	22,119	0		9.00	
10.00	RADIOISOTOPE	56.00	0	56,786	0		10.00	
11.00	ULTRASOUND	56.01	0	32,340	0		11.00	
12.00	CT SCAN	57.00	0	16,131	0		12.00	
13.00	MRI	58.00	0	17,794	0		13.00	
14.00	CARDIAC CATHETERIZATION	59.00	0	619,407	0		14.00	
15.00	LABORATORY	60.00	0	344,981	0		15.00	

RECLASSIFICATIONS

Provider CCN: 14-0008

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

Worksheet A-6

Date/Time Prepared:
1/28/2021 3:56 pm

		Decreases					1/28/2021 3:36 pm	
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.			
	6.00	7.00	8.00	9.00	10.00			
16.00	RESPIRATORY THERAPY	65.00	0	53,844	0		16.00	
17.00	PHYSICAL THERAPY	66.00	0	13,227	0		17.00	
18.00	OCCUPATIONAL THERAPY	67.00	0	711	0		18.00	
19.00	SPEECH PATHOLOGY	68.00	0	59,491	0		19.00	
20.00	ELECTROCARDIOLOGY	69.00	0	18,016	0		20.00	
21.00	ELECTROENCEPHALOGRAPHY	70.00	0	28,037	0		21.00	
22.00	CARDIAC REHABILITATION	76.01	0	2,192	0		22.00	
23.00	GASTROINTESTINAL SERVICES	76.02	0	292,852	0		23.00	
24.00	CLINIC	90.00	0	25,944	0		24.00	
25.00	WOUND CARE	90.02	0	54,921	0		25.00	
26.00	EMERGENCY	91.00	0	311,486	0		26.00	
0			0	4,670,524				
L - Implantable Devices								
1.00	ADMINISTRATIVE & GENERAL	5.00	0	2	0		1.00	
2.00	NURSING ADMINISTRATION	13.00	0	5	0		2.00	
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	7,324	0		3.00	
4.00	PHARMACY	15.00	0	55	0		4.00	
5.00	SOCIAL SERVICE	17.00	0	14	0		5.00	
6.00	ADULTS & PEDIATRICS	30.00	0	46	0		6.00	
7.00	SUBPROVIDER - IPF	40.00	0	5	0		7.00	
8.00	SUBPROVIDER - IRF	41.00	0	32	0		8.00	
9.00	SKILLED NURSING FACILITY	44.00	0	5	0		9.00	
10.00	OPERATING ROOM	50.00	0	3,944,672	0		10.00	
11.00	RECOVERY ROOM	51.00	0	5	0		11.00	
12.00	RADIOLOGY-DIAGNOSTIC	54.00	0	113	0		12.00	
13.00	RADIOISOTOPE	56.00	0	5	0		13.00	
14.00	ULTRASOUND	56.01	0	74	0		14.00	
15.00	CARDIAC CATHETERIZATION	59.00	0	347,637	0		15.00	
16.00	PHYSICAL THERAPY	66.00	0	5	0		16.00	
17.00	ELECTROCARDIOLOGY	69.00	0	5	0		17.00	
18.00	CARDIAC REHABILITATION	76.01	0	5	0		18.00	
19.00	GASTROINTESTINAL SERVICES	76.02	0	55,478	0		19.00	
20.00	CLINIC	90.00	0	5	0		20.00	
21.00	WOUND CARE	90.02	0	339,064	0		21.00	
22.00	EMERGENCY	91.00	0	2,487	0		22.00	
0			0	4,697,043				
N - Capital Movable Equipment								
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	3,451,501	9		1.00	
2.00	ADMINISTRATIVE & GENERAL	5.00	0	2,935	0		2.00	
3.00	OPERATION OF PLANT	7.00	0	13,460	0		3.00	
4.00	NURSING ADMINISTRATION	13.00	0	1,063	0		4.00	
5.00	CENTRAL SERVICES & SUPPLY	14.00	0	6,695	0		5.00	
6.00	OPERATING ROOM	50.00	0	568	0		6.00	
7.00	SPEECH PATHOLOGY	68.00	0	958	0		7.00	
8.00	CARDIAC REHABILITATION	76.01	0	749	0		8.00	
9.00	EMERGENCY	91.00	0	1,604	0		9.00	
0			0	3,479,533				
O - Interest Expense								
1.00	ADMINISTRATIVE & GENERAL	5.00	0	590,100	11		1.00	
0			0	590,100				
P - Nursing Admin								
1.00	ADMINISTRATIVE & GENERAL	5.00	103,842	20,505			1.00	
			103,842	20,505				
Q - Laundry Depart Return								
1.00	ADMINISTRATIVE & GENERAL	5.00	0	12,547	0		1.00	
2.00	MAINTENANCE & REPAIRS	6.00	0	3,070	0		2.00	
3.00	OPERATION OF PLANT	7.00	0	8,486	0		3.00	
4.00	HOUSEKEEPING	9.00	0	16,408	0		4.00	
5.00	DIETARY	10.00	0	7,179	0		5.00	
6.00	CAFETERIA	11.00	0	13,483	0		6.00	
7.00	NURSING ADMINISTRATION	13.00	0	129	0		7.00	
8.00	CENTRAL SERVICES & SUPPLY	14.00	0	304	0		8.00	
9.00	PHARMACY	15.00	0	655	0		9.00	
10.00	ADULTS & PEDIATRICS	30.00	0	381	0		10.00	
11.00	INTENSIVE CARE UNIT	31.00	0	39,598	0		11.00	
12.00	SUBPROVIDER - IPF	40.00	0	838	0		12.00	
13.00	SUBPROVIDER - IRF	41.00	0	273	0		13.00	
14.00	OPERATING ROOM	50.00	0	2,962	0		14.00	
15.00	LABORATORY	60.00	0	568	0		15.00	
16.00	PHYSICAL THERAPY	66.00	0	63	0		16.00	
17.00	EMERGENCY	91.00	0	254	0		17.00	
	TOTALS		0	107,198				

RECLASSIFICATIONS

Provider CCN: 14-0008

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

Worksheet A-6

Date/Time Prepared:
1/28/2021 3:56 pm

	Decreases				wkst. A-7 Ref.		
	Cost Center	Line #	Salary	Other			
	6.00	7.00	8.00	9.00	10.00		
	R - Same Day Surgery						
1.00	LABORATORY	60.00		15			1.00
2.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00		25,944			2.00
3.00	IMPL. DEV. CHARGED TO PATIENTS	72.00		5			3.00
4.00	DRUGS CHARGED TO PATIENTS	73.00		7,376			4.00
5.00	CLINIC	90.00	794,379	152,168			5.00
			794,379	185,508			
500.00	Grand Total: Decreases		1,658,175	16,489,111			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0008

Period:
From 07/01/2019
To 06/30/2020Worksheet A-7
Part I
Date/Time Prepared:
1/28/2021 3:56 pm

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	12,500,000	0	0	0	0	1.00	
2.00	Land Improvements	1,249,191	0	0	0	0	2.00	
3.00	Buildings and Fixtures	54,881,795	11,990,470	0	11,990,470	0	3.00	
4.00	Building Improvements	16,799,939	420,391	0	420,391	0	4.00	
5.00	Fixed Equipment	0	0	0	0	0	5.00	
6.00	Movable Equipment	48,329,609	1,112,551	0	1,112,551	0	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	133,760,534	13,523,412	0	13,523,412	0	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	133,760,534	13,523,412	0	13,523,412	0	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	12,500,000	0				1.00	
2.00	Land Improvements	1,249,191	0				2.00	
3.00	Buildings and Fixtures	66,872,265	0				3.00	
4.00	Building Improvements	17,220,330	0				4.00	
5.00	Fixed Equipment	0	0				5.00	
6.00	Movable Equipment	49,442,160	0				6.00	
7.00	HIT designated Assets	0	0				7.00	
8.00	Subtotal (sum of lines 1-7)	147,283,946	0				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	147,283,946	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0008

Period:
From 07/01/2019
To 06/30/2020Worksheet A-7
Part II
Date/Time Prepared:
1/28/2021 3:56 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	9,441,666	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	9,441,666	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other	Total (1) (sum				
		Capital-Relate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		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	9,441,666				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	9,441,666				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0008

Period:
From 07/01/2019
To 06/30/2020Worksheet A-7
Part III
Date/Time Prepared:
1/28/2021 3:56 pm

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	97,841,785	0	97,841,785	0.664307	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	49,442,161	0	49,442,161	0.335693	0	2.00
3.00	Total (sum of lines 1-2)	147,283,946	0	147,283,946	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	5,941,087	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	3,479,533	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	9,420,620	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	410,146	0	0	0	6,351,233	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	3,479,533	2.00
3.00	Total (sum of lines 1-2)	410,146	0	0	0	9,830,766	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0008

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

Worksheet A-8

Date/Time Prepared:
1/28/2021 3:56 pm

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-72,128	ADMINISTRATIVE & GENERAL	5.00	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	-614,967			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	2,189,550			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	0	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		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	B	0	CAFETERIA	11.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH 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: 14-0008

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

Worksheet A-8

Date/Time Prepared:
1/28/2021 3:56 pm

			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
35.07 MISC INCOME A&G	B	-2,498,044	ADMINISTRATIVE & GENERAL	5.00	0	35.07
35.08 MISC OTHER INCOME AUDIOLOGY	B	0	SPEECH PATHOLOGY	68.00	0	35.08
35.09 MISC OTHER INCOME BIRTH CENTER	B	0	ADULTS & PEDIATRICS	30.00	0	35.09
35.10 GIFT NET ASSET RELEASE FROM RESTR	B	0	ADMINISTRATIVE & GENERAL	5.00	0	35.10
35.15 WEST TOWNS 958.729	A	-140,527	ADMINISTRATIVE & GENERAL	5.00	0	35.15
35.19 EMPLOYEE DAY CARE REVENUE	B	-333,179	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	35.19
35.20 Excluded Individual Offset	A	0	DIETARY	10.00	0	35.20
37.00 DIETARY	B	-156,957	DIETARY	10.00	0	37.00
39.00 BPCI Gain/Loss	A	-330,509	SOCIAL SERVICE	17.00	0	39.00
40.00 Grants & Gifts	A	-33,439	ADMINISTRATIVE & GENERAL	5.00	0	40.00
41.00 ADVERTISING	A	-2,747	ADMINISTRATIVE & GENERAL	5.00	0	41.00
42.00 MISC NURSING DEVELOPMENT	B	0	NURSING ADMINISTRATION	13.00	0	42.00
42.01 HAIP/ACA PROGRAM BENEFIT OFFSET	A	-2,467,464	ADMINISTRATIVE & GENERAL	5.00	0	42.01
42.02 Gottlieb Center for Fitness	B	-1,519,612	ADMINISTRATIVE & GENERAL	5.00	0	42.02
42.03 OUTREACH NON PATIENT LAB	B	-1,725,636	LABORATORY	60.00	0	42.03
42.04 Physician Prof Expense Offset	A	-1,190,970	ADMINISTRATIVE & GENERAL	5.00	0	42.04
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-8,896,629				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: 14-0008

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

Worksheet A-8-1

Date/Time Prepared:
1/28/2021 3:56 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00		1.00	CAP REL COSTS-BLDG & FIXT	397,446	590,100	1.00
2.00		5.00	ADMINISTRATIVE & GENERAL	4,856,715	9,289,639	2.00
3.00		1.00	CAP REL COSTS-BLDG & FIXT	12,700	0	3.00
3.01		5.00	ADMINISTRATIVE & GENERAL	4,571,437	0	3.01
3.02		5.00	ADMINISTRATIVE & GENERAL	3,254,910	0	3.02
3.03		5.00	ADMINISTRATIVE & GENERAL	948,536	343,112	3.03
3.04		5.00	ADMINISTRATIVE & GENERAL	63,396	0	3.04
3.05		5.00	ADMINISTRATIVE & GENERAL	71,057	0	3.05
3.06		5.00	ADMINISTRATIVE & GENERAL	0	20,000	3.06
3.07		4.00	EMPLOYEE BENEFITS DEPARTMENT	0	61,734	3.07
3.08		22.00	I&R SERVICES-OTHER PRGM COST	322,612	322,612	3.08
3.09		5.00	ADMINISTRATIVE & GENERAL	0	1,632,984	3.09
3.11		1.00	CAP REL COSTS-BLDG & FIXT	0	49,078	3.11
4.00		0.00	EMPLOYEE BENEFITS SEVERANCE	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.	14,498,809	12,309,259	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	B	0.00	TRINITY HEALTH	100.00	6.00
7.00		0.00		0.00	7.00
8.00		0.00		0.00	8.00
9.00		0.00		0.00	9.00
10.00		0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:				100.00

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

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

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

Provider CCN: 14-0008

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

Worksheet A-8-1

Date/Time Prepared:
1/28/2021 3:56 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	-192,654	11		1.00
2.00	-4,432,924	0		2.00
3.00	12,700	11		3.00
3.01	4,571,437	0		3.01
3.02	3,254,910	0		3.02
3.03	605,424	0		3.03
3.04	63,396	0		3.04
3.05	71,057	0		3.05
3.06	-20,000	0		3.06
3.07	-61,734	0		3.07
3.08	0	0		3.08
3.09	-1,632,984	0		3.09
3.11	-49,078	9		3.11
4.00	0	0		4.00
5.00	2,189,550			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	HEALTHCARE SYSTEM	6.00
7.00		7.00
8.00		8.00
9.00		9.00
10.00		10.00
100.00		100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0008

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

Worksheet A-8-2

Date/Time Prepared:
1/28/2021 3:56 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	40.00	SUBPROVIDER - IPF	153,600	153,600	0	211,500	0	1.00
2.00	41.00	SUBPROVIDER - IRF	5,000	5,000	0	0	0	2.00
3.00	50.00	OPERATING ROOM	168,865	168,865	0	0	0	3.00
4.00	53.00	ANESTHESIOLOGY	162,502	162,502	0	0	0	4.00
5.00	91.00	EMERGENCY	125,000	125,000	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			614,967	614,967	0	0	0	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	40.00	SUBPROVIDER - IPF	0	0	0	0	0	1.00
2.00	41.00	SUBPROVIDER - IRF	0	0	0	0	0	2.00
3.00	50.00	OPERATING ROOM	0	0	0	0	0	3.00
4.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	4.00
5.00	91.00	EMERGENCY	0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	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	40.00	SUBPROVIDER - IPF	0	0	0	153,600		1.00
2.00	41.00	SUBPROVIDER - IRF	0	0	0	5,000		2.00
3.00	50.00	OPERATING ROOM	0	0	0	168,865		3.00
4.00	53.00	ANESTHESIOLOGY	0	0	0	162,502		4.00
5.00	91.00	EMERGENCY	0	0	0	125,000		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	614,967		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0008

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part I
Date/Time Prepared:
1/28/2021 3:56 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	4A
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	6,351,233	6,351,233			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	3,479,533		3,479,533		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	159,151	168,015	12,760	339,926	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	23,343,315	526,269	310,867	21,236	5.00
6.00	00600	MAINTENANCE & REPAIRS	2,691,813	40,950	69,247	6,471	6.00
7.00	00700	OPERATION OF PLANT	4,342,337	1,561,890	173,201	5,634	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	107,132	25,744	0	0	8.00
9.00	00900	HOUSEKEEPING	3,517,998	24,766	1,054	10,067	9.00
10.00	01000	DIETARY	531,563	130,245	11,107	3,032	10.00
11.00	01100	CAFETERIA	1,293,146	118,145	20,915	5,695	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	1,537,883	31,183	23,442	9,573	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,479,267	168,448	167,420	7,778	14.00
15.00	01500	PHARMACY	3,902,536	58,094	260,674	14,935	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	26,346	0	0	16.00
17.00	01700	SOCIAL SERVICE	379,885	11,047	0	4,057	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	328,980	0	0	0	22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	10,364,493	783,335	105,523	61,848	30.00
31.00	03100	INTENSIVE CARE UNIT	3,851,515	201,494	161,784	22,215	31.00
40.00	04000	SUBPROVIDER - IPF	1,251,653	99,834	843	7,947	40.00
41.00	04100	SUBPROVIDER - IRF	2,271,460	190,390	31,930	13,466	41.00
43.00	04300	NURSERY	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	3,080,347	215,438	15,483	14,783	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	5,405,428	510,292	834,841	20,387	50.00
51.00	05100	RECOVERY ROOM	512,357	12,684	36,608	3,098	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	205,318	11,611	137,704	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,996,718	185,065	164,703	12,046	54.00
56.00	05600	RADIOISOTOPE	329,938	30,261	295	1,228	56.00
56.01	03630	ULTRASOUND	568,883	25,048	40,729	3,642	56.01
57.00	05700	CT SCAN	656,764	41,928	44,960	3,555	57.00
58.00	05800	MRI	217,946	49,456	137,918	1,222	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,026,049	47,762	299,215	4,581	59.00
60.00	06000	LABORATORY	3,980,271	181,847	20,953	16,134	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,640,702	19,873	8,737	8,600	65.00
66.00	06600	PHYSICAL THERAPY	2,315,679	120,008	3,344	14,840	66.00
67.00	06700	OCCUPATIONAL THERAPY	320,496	31,145	0	2,083	67.00
68.00	06800	SPEECH PATHOLOGY	235,419	114,099	2,617	1,450	68.00
69.00	06900	ELECTROCARDIOLOGY	533,004	7,960	6,617	2,664	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	120,268	16,730	8,326	665	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,644,580	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,696,984	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	857,384	0	0	0	73.00
73.01	07301	OUTPATIENT PHARMACY	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03950	LITHOTRIPSY	0	0	0	0	76.00
76.01	03951	CARDIAC REHABILITATION	168,972	67,917	5,276	1,084	76.01
76.02	03020	GASTROINTESTINAL SERVICES	1,219,883	65,659	37,234	5,678	76.02
76.03	03030	ANGIOCARDIOGRAPHY	0	0	0	0	76.03
76.05	03954	INPATIENT RENAL DIALYSIS	0	0	0	0	76.05
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	13,848	0	90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES	0	0	0	0	90.01
90.02	04950	WOUND CARE	750,464	42,041	0	128	90.02
90.03	09003	RIVER FOREST	0	0	0	0	90.03
91.00	09100	EMERGENCY	4,441,912	187,944	276,016	24,095	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0008

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part I
Date/Time Prepared:
1/28/2021 3:56 pm

Cost Center Description		Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	4.00	4A	
OTHER REIMBURSABLE COST CENTERS							
99.10	09910 CORF	0	0	0	0	0	99.10
99.20	09920 OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930 OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940 OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	111,110,659	6,150,963	3,446,191	335,917	110,873,038	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	77,541	72,471	33,342	175	183,529	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201 NON-EMPLOYEE CHILD CARE CENTER	0	0	0	0	0	192.01
192.02	19202 OUTPATIENT PHARMACY	1,706,447	58,094	0	2,909	1,767,450	192.02
192.03	19203 WEST TOWN PHO	0	0	0	0	0	192.03
193.00	19300 NONPAID WORKERS	16,282	39,971	0	0	56,253	193.00
193.01	19301 ADULT DAY CARE	159,547	29,734	0	925	190,206	193.01
194.00	07950 DISCONTINUED HOME HEALTH AND HOSPICE	0	0	0	0	0	194.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	113,070,476	6,351,233	3,479,533	339,926	113,070,476	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0008

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part I
Date/Time Prepared:
1/28/2021 3:56 pm

Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	24,201,687					5.00
6.00	00600	MAINTENANCE & REPAIRS	764,836	3,573,317				6.00
7.00	00700	OPERATION OF PLANT	1,656,606	993,787	8,733,455			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	36,186	16,380	55,459	240,901		8.00
9.00	00900	HOUSEKEEPING	967,833	15,758	53,351	47,569	4,638,396	9.00
10.00	01000	DIETARY	184,081	82,872	280,577	59,900	150,897	10.00
11.00	01100	CAFETERIA	391,585	75,173	254,510	0	136,877	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	436,296	19,841	67,175	375	36,127	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	496,436	107,179	362,874	881	195,156	14.00
15.00	01500	PHARMACY	1,153,659	36,964	125,147	1,900	67,305	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	7,175	16,764	56,756	0	30,524	16.00
17.00	01700	SOCIAL SERVICE	107,568	7,029	23,797	0	12,798	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	89,591	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	3,081,443	498,416	1,687,479	1,104	907,538	30.00
31.00	03100	INTENSIVE CARE UNIT	1,153,869	128,205	434,062	114,798	233,442	31.00
40.00	04000	SUBPROVIDER - IPF	370,446	63,522	215,065	2,428	115,663	40.00
41.00	04100	SUBPROVIDER - IRF	682,801	121,141	410,143	792	220,578	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	905,787	137,078	464,102	0	249,597	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,843,939	324,686	1,099,283	8,588	591,202	50.00
51.00	05100	RECOVERY ROOM	153,798	8,070	27,324	0	14,695	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	96,578	7,388	25,013	0	13,452	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	642,301	117,752	398,671	0	214,408	54.00
56.00	05600	RADIOISOTOPE	98,508	19,254	65,188	0	35,059	56.00
56.01	03630	ULTRASOUND	173,829	15,937	53,959	0	29,019	56.01
57.00	05700	CT SCAN	203,488	26,678	90,323	0	48,576	57.00
58.00	05800	MRI	110,714	31,468	106,539	0	57,298	58.00
59.00	05900	CARDIAC CATHETERIZATION	375,165	30,390	102,891	0	55,335	59.00
60.00	06000	LABORATORY	1,143,574	115,704	391,738	1,647	210,680	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	456,947	12,645	42,810	0	23,024	65.00
66.00	06600	PHYSICAL THERAPY	668,265	76,358	258,524	182	139,036	66.00
67.00	06700	OCCUPATIONAL THERAPY	96,330	19,817	67,094	0	36,083	67.00
68.00	06800	SPEECH PATHOLOGY	96,292	72,598	245,794	0	132,190	68.00
69.00	06900	ELECTROCARDIOLOGY	149,849	5,065	17,148	0	9,223	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	39,757	10,645	36,040	0	19,383	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,264,863	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,279,134	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	233,492	0	0	0	0	73.00
73.01	07301	OUTPATIENT PHARMACY	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	LITHOTRIPSY	0	0	0	0	0	76.00
76.01	03951	CARDIAC REHABILITATION	66,244	43,214	146,309	0	78,686	76.01
76.02	03020	GASTROINTESTINAL SERVICES	361,779	41,777	141,444	0	76,070	76.02
76.03	03030	ANGIOCARDIOGRAPHY	0	0	0	0	0	76.03
76.05	03954	INPATIENT RENAL DIALYSIS	0	0	0	0	0	76.05
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	3,771	0	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES	0	0	0	0	0	90.01
90.02	04950	WOUND CARE	215,859	26,750	90,566	0	48,707	90.02
90.03	09003	RIVER FOREST	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	1,342,583	119,584	404,873	737	217,744	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
		5.00	6.00	7.00	8.00	9.00	
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	23,603,257	3,445,889	8,302,028	240,901	4,406,372	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	49,981	46,112	156,120	0	83,962	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201 NON-EMPLOYEE CHILD CARE CENTER	0	0	0	0	0	192.01
192.02	19202 OUTPATIENT PHARMACY	481,331	36,964	125,147	0	67,305	192.02
192.03	19203 WEST TOWN PHO	0	0	0	0	0	192.03
193.00	19300 NONPAID WORKERS	15,319	25,433	86,107	0	46,309	193.00
193.01	19301 ADULT DAY CARE	51,799	18,919	64,053	0	34,448	193.01
194.00	07950 DISCONTINUED HOME HEALTH AND HOSPICE	0	0	0	0	0	194.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	24,201,687	3,573,317	8,733,455	240,901	4,638,396	202.00

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Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	1,434,274					10.00
11.00	01100	CAFETERIA	641,673	2,937,719				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	61,344	0	2,223,239		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	121,516	0	1,866	3,108,821	14.00
15.00	01500	PHARMACY	0	119,297	0	0	38,805	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	4,254	0	786	842	16.00
17.00	01700	SOCIAL SERVICE	0	43,526	0	0	68	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	299	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	253,059	660,045	0	859,403	10,608	30.00
31.00	03100	INTENSIVE CARE UNIT	47,609	174,229	0	268,662	4,090	31.00
40.00	04000	SUBPROVIDER - IPF	38,680	90,012	0	91,518	589	40.00
41.00	04100	SUBPROVIDER - IRF	66,915	138,717	0	165,164	3,252	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	92,066	169,605	0	179,501	3,251	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	194,081	0	161,728	106,550	50.00
51.00	05100	RECOVERY ROOM	0	22,318	0	32,994	254	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	1,911	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	121,886	0	15,908	1,831	54.00
56.00	05600	RADIOISOTOPE	0	9,124	0	0	157	56.00
56.01	03630	ULTRASOUND	0	27,620	0	0	498	56.01
57.00	05700	CT SCAN	0	28,483	0	0	3,926	57.00
58.00	05800	MRI	0	10,358	0	0	262	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	28,298	0	11,685	9,281	59.00
60.00	06000	LABORATORY	0	202,958	0	0	398,832	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	85,881	0	0	14,127	65.00
66.00	06600	PHYSICAL THERAPY	0	142,108	0	4,419	315	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	16,153	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	16,461	0	0	52	68.00
69.00	06900	ELECTROCARDIOLOGY	0	28,052	0	4,812	630	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	8,570	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	1,327,172	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	1,155,516	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	OUTPATIENT PHARMACY	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	LITHOTRIPSY	0	0	0	0	0	76.00
76.01	03951	CARDIAC REHABILITATION	0	10,481	0	6,088	189	76.01
76.02	03020	GASTROINTESTINAL SERVICES	0	55,733	0	64,220	5,958	76.02
76.03	03030	ANGIOCARDIOGRAPHY	0	0	0	0	0	76.03
76.05	03954	INPATIENT RENAL DIALYSIS	0	0	0	0	0	76.05
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	50,000	0	59,703	0	90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES	0	0	0	0	0	90.01
90.02	04950	WOUND CARE	0	2,158	0	3,437	4,501	90.02
90.03	09003	RIVER FOREST	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	254,376	0	286,239	5,891	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40

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Cost Center Description		DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
		10.00	11.00	12.00	13.00	14.00	
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	1,140,002	2,897,644	0	2,218,133	3,099,657	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,131	0	0	272	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	294,272	0	0	0	0	192.00
192.01	19201 NON-EMPLOYEE CHILD CARE CENTER	0	0	0	0	0	192.01
192.02	19202 OUTPATIENT PHARMACY	0	24,168	0	0	8,143	192.02
192.03	19203 WEST TOWN PHO	0	0	0	0	0	192.03
193.00	19300 NONPAID WORKERS	0	0	0	0	477	193.00
193.01	19301 ADULT DAY CARE	0	11,776	0	5,106	222	193.01
194.00	07950 DISCONTINUED HOME HEALTH AND HOSPICE	0	0	0	0	50	194.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	1,434,274	2,937,719	0	2,223,239	3,108,821	202.00

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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
			15.00	16.00	17.00	19.00	20.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	5,779,316					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	143,447				16.00
17.00	01700	SOCIAL SERVICE	0	0	589,775			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
20.00	02000	NURSING SCHOOL	0	0	0		0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	24,058	298,299	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	5,301	56,329	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	2,504	46,017	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	3,445	79,607	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	4,081	109,523	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	6,691	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	2,840	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	4,121	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,004	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	912	0	0	0	56.00
56.01	03630	ULTRASOUND	0	2,616	0	0	0	56.01
57.00	05700	CT SCAN	0	10,414	0	0	0	57.00
58.00	05800	MRI	0	2,732	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	4,008	0	0	0	59.00
60.00	06000	LABORATORY	0	15,904	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	2,811	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	4,570	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	725	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	286	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	3,980	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	500	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,863	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,551	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,406,614	6,025	0	0	0	73.00
73.01	07301	OUTPATIENT PHARMACY	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	LITHOTRIPSY	0	0	0	0	0	76.00
76.01	03951	CARDIAC REHABILITATION	0	364	0	0	0	76.01
76.02	03020	GASTROINTESTINAL SERVICES	0	6,845	0	0	0	76.02
76.03	03030	ANGIOCARDIOGRAPHY	0	0	0	0	0	76.03
76.05	03954	INPATIENT RENAL DIALYSIS	0	0	0	0	0	76.05
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	4	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES	0	0	0	0	0	90.01
90.02	04950	WOUND CARE	0	1,150	0	0	0	90.02
90.03	09003	RIVER FOREST	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	17,142	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40

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Cost Center Description		PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
		15.00	16.00	17.00	19.00	20.00	
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	4,406,614	143,447	589,775	0	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	934	0	0	0	0	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201 NON-EMPLOYEE CHILD CARE CENTER	0	0	0	0	0	192.01
192.02	19202 OUTPATIENT PHARMACY	1,371,747	0	0	0	0	192.02
192.03	19203 WEST TOWN PHO	0	0	0	0	0	192.03
193.00	19300 NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301 ADULT DAY CARE	0	0	0	0	0	193.01
194.00	07950 DISCONTINUED HOME HEALTH AND HOSPICE	21	0	0	0	0	194.00
200.00	Cross Foot Adjustments					0	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	5,779,316	143,447	589,775	0	0	202.00

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Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			SERVICES-SALAR Y & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
			21.00	22.00	23.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
20.00	02000	NURSING SCHOOL						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		418,870				22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)			0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	4,189	0	19,600,840	-4,189	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	6,857,604	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	2,396,721	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	4,399,801	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	5,640,642	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	11,107,696	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	827,040	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	503,096	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	3,876,293	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	589,924	0	56.00
56.01	03630	ULTRASOUND	0	0	0	941,780	0	56.01
57.00	05700	CT SCAN	0	0	0	1,159,095	0	57.00
58.00	05800	MRI	0	0	0	725,913	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	1,994,660	0	59.00
60.00	06000	LABORATORY	0	0	0	6,680,242	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,316,157	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	3,747,648	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	589,926	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	917,258	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	769,004	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	260,884	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	7,238,478	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	7,134,185	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	5,503,515	0	73.00
73.01	07301	OUTPATIENT PHARMACY	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	LITHOTRIPSY	0	0	0	0	0	76.00
76.01	03951	CARDIAC REHABILITATION	0	0	0	594,824	0	76.01
76.02	03020	GASTROINTESTINAL SERVICES	0	0	0	2,082,280	0	76.02
76.03	03030	ANGIOCARDIOGRAPHY	0	0	0	0	0	76.03
76.05	03954	INPATIENT RENAL DIALYSIS	0	0	0	0	0	76.05
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	127,326	0	90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES	0	0	0	0	0	90.01
90.02	04950	WOUND CARE	0	0	0	1,185,761	0	90.02
90.03	09003	RIVER FOREST	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	414,681	0	7,993,817	-414,681	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0008

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Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
			21.00	22.00	23.00	24.00	25.00	
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00	SUBTOTALS (SUM OF LINES 1 through 117)		0	418,870	0	107,762,410	-418,870	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	525,041	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	294,272	0	192.00
192.01	19201	NON-EMPLOYEE CHILD CARE CENTER	0	0	0	0	0	192.01
192.02	19202	OUTPATIENT PHARMACY	0	0	0	3,882,255	0	192.02
192.03	19203	WEST TOWN PHO	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	229,898	0	193.00
193.01	19301	ADULT DAY CARE	0	0	0	376,529	0	193.01
194.00	07950	DISCONTINUED HOME HEALTH AND HOSPICE	0	0	0	71	0	194.00
200.00	Cross Foot Adjustments		0	0	0	0	0	200.00
201.00	Negative Cost Centers		0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)		0	418,870	0	113,070,476	-418,870	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description			Total	
			26.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
6.00	00600	MAINTENANCE & REPAIRS		6.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
12.00	01200	MAINTENANCE OF PERSONNEL		12.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS		19.00
20.00	02000	NURSING SCHOOL		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)		23.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	19,596,651	30.00
31.00	03100	INTENSIVE CARE UNIT	6,857,604	31.00
40.00	04000	SUBPROVIDER - IPF	2,396,721	40.00
41.00	04100	SUBPROVIDER - IRF	4,399,801	41.00
43.00	04300	NURSERY	0	43.00
44.00	04400	SKILLED NURSING FACILITY	5,640,642	44.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	11,107,696	50.00
51.00	05100	RECOVERY ROOM	827,040	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	52.00
53.00	05300	ANESTHESIOLOGY	503,096	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,876,293	54.00
56.00	05600	RADIOISOTOPE	589,924	56.00
56.01	03630	ULTRASOUND	941,780	56.01
57.00	05700	CT SCAN	1,159,095	57.00
58.00	05800	MRI	725,913	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,994,660	59.00
60.00	06000	LABORATORY	6,680,242	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	62.30
65.00	06500	RESPIRATORY THERAPY	2,316,157	65.00
66.00	06600	PHYSICAL THERAPY	3,747,648	66.00
67.00	06700	OCCUPATIONAL THERAPY	589,926	67.00
68.00	06800	SPEECH PATHOLOGY	917,258	68.00
69.00	06900	ELECTROCARDIOLOGY	769,004	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	260,884	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,238,478	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,134,185	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,503,515	73.00
73.01	07301	OUTPATIENT PHARMACY	0	73.01
74.00	07400	RENAL DIALYSIS	0	74.00
76.00	03950	LITHOTRIPSY	0	76.00
76.01	03951	CARDIAC REHABILITATION	594,824	76.01
76.02	03020	GASTROINTESTINAL SERVICES	2,082,280	76.02
76.03	03030	ANGIOCARDIOGRAPHY	0	76.03
76.05	03954	INPATIENT RENAL DIALYSIS	0	76.05
76.97	07697	CARDIAC REHABILITATION	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	76.98
76.99	07699	LITHOTRIPSY	0	76.99
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	127,326	90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES	0	90.01
90.02	04950	WOUND CARE	1,185,761	90.02
90.03	09003	RIVER FOREST	0	90.03
91.00	09100	EMERGENCY	7,579,136	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		92.00
OTHER REIMBURSABLE COST CENTERS				
99.10	09910	CORF	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	99.40
SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	107,343,540	118.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description		Total	
		26.00	
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	525,041
192.00	19200	PHYSICIANS' PRIVATE OFFICES	294,272
192.01	19201	NON-EMPLOYEE CHILD CARE CENTER	0
192.02	19202	OUTPATIENT PHARMACY	3,882,255
192.03	19203	WEST TOWN PHO	0
193.00	19300	NONPAID WORKERS	229,898
193.01	19301	ADULT DAY CARE	376,529
194.00	07950	DISCONTINUED HOME HEALTH AND HOSPICE	71
200.00		Cross Foot Adjustments	0
201.00		Negative Cost Centers	0
202.00		TOTAL (sum lines 118 through 201)	112,651,606

190.00
192.00
192.01
192.02
192.03
193.00
193.01
194.00
200.00
201.00
202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0008

Period:
From 07/01/2019
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Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	168,015	12,760	180,775	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	526,269	310,867	837,136	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	40,950	69,247	110,197	6.00
7.00	00700	OPERATION OF PLANT	0	1,561,890	173,201	1,735,091	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	25,744	0	25,744	8.00
9.00	00900	HOUSEKEEPING	0	24,766	1,054	25,820	9.00
10.00	01000	DIETARY	0	130,245	11,107	141,352	10.00
11.00	01100	CAFETERIA	0	118,145	20,915	139,060	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	31,183	23,442	54,625	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	168,448	167,420	335,868	14.00
15.00	01500	PHARMACY	0	58,094	260,674	318,768	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	26,346	0	26,346	16.00
17.00	01700	SOCIAL SERVICE	0	11,047	0	11,047	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	783,335	105,523	888,858	30.00
31.00	03100	INTENSIVE CARE UNIT	0	201,494	161,784	363,278	31.00
40.00	04000	SUBPROVIDER - IPF	0	99,834	843	100,677	40.00
41.00	04100	SUBPROVIDER - IRF	0	190,390	31,930	222,320	41.00
43.00	04300	NURSERY	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	215,438	15,483	230,921	44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	510,292	834,841	1,345,133	50.00
51.00	05100	RECOVERY ROOM	0	12,684	36,608	49,292	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	11,611	137,704	149,315	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	185,065	164,703	349,768	54.00
56.00	05600	RADIOISOTOPE	0	30,261	295	30,556	56.00
56.01	03630	ULTRASOUND	0	25,048	40,729	65,777	56.01
57.00	05700	CT SCAN	0	41,928	44,960	86,888	57.00
58.00	05800	MRI	0	49,456	137,918	187,374	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	47,762	299,215	346,977	59.00
60.00	06000	LABORATORY	0	181,847	20,953	202,800	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	19,873	8,737	28,610	65.00
66.00	06600	PHYSICAL THERAPY	0	120,008	3,344	123,352	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	31,145	0	31,145	67.00
68.00	06800	SPEECH PATHOLOGY	0	114,099	2,617	116,716	68.00
69.00	06900	ELECTROCARDIOLOGY	0	7,960	6,617	14,577	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	16,730	8,326	25,056	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
73.01	07301	OUTPATIENT PHARMACY	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00	03950	LITHOTRIPSY	0	0	0	0	76.00
76.01	03951	CARDIAC REHABILITATION	0	67,917	5,276	73,193	76.01
76.02	03020	GASTROINTESTINAL SERVICES	0	65,659	37,234	102,893	76.02
76.03	03030	ANGIOCARDIOGRAPHY	0	0	0	0	76.03
76.05	03954	INPATIENT RENAL DIALYSIS	0	0	0	0	76.05
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	13,848	13,848	90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES	0	0	0	0	90.01
90.02	04950	WOUND CARE	0	42,041	0	42,041	90.02
90.03	09003	RIVER FOREST	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	187,944	276,016	463,960	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	99.10

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	2A	4.00	
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	6,150,963	3,446,191	9,597,154	178,643	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	72,471	33,342	105,813	93	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	NON-EMPLOYEE CHILD CARE CENTER	0	0	0	0	0	192.01
192.02	19202	OUTPATIENT PHARMACY	0	58,094	0	58,094	1,547	192.02
192.03	19203	WEST TOWN PHO	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	39,971	0	39,971	0	193.00
193.01	19301	ADULT DAY CARE	0	29,734	0	29,734	492	193.01
194.00	07950	DISCONTINUED HOME HEALTH AND HOSPICE	0	0	0	0	0	194.00
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)	0	6,351,233	3,479,533	9,830,766	180,775	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	848,432					5.00
6.00	00600	MAINTENANCE & REPAIRS	26,813	140,452				6.00
7.00	00700	OPERATION OF PLANT	58,075	39,062	1,835,225			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,269	644	11,654	39,311		8.00
9.00	00900	HOUSEKEEPING	33,929	619	11,211	7,762	84,696	9.00
10.00	01000	DIETARY	6,453	3,257	58,960	9,775	2,755	10.00
11.00	01100	CAFETERIA	13,728	2,955	53,482	0	2,499	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	15,295	780	14,116	61	660	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	17,403	4,213	76,253	144	3,564	14.00
15.00	01500	PHARMACY	40,443	1,453	26,298	310	1,229	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	252	659	11,927	0	557	16.00
17.00	01700	SOCIAL SERVICE	3,771	276	5,001	0	234	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	3,141	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	108,026	19,591	354,601	180	16,571	30.00
31.00	03100	INTENSIVE CARE UNIT	40,451	5,039	91,213	18,734	4,263	31.00
40.00	04000	SUBPROVIDER - IPF	12,987	2,497	45,193	396	2,112	40.00
41.00	04100	SUBPROVIDER - IRF	23,937	4,762	86,186	129	4,028	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	31,754	5,388	97,525	0	4,558	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	64,642	12,762	231,000	1,401	10,795	50.00
51.00	05100	RECOVERY ROOM	5,392	317	5,742	0	268	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	3,386	290	5,256	0	246	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	22,517	4,628	83,776	0	3,915	54.00
56.00	05600	RADIOISOTOPE	3,453	757	13,699	0	640	56.00
56.01	03630	ULTRASOUND	6,094	626	11,339	0	530	56.01
57.00	05700	CT SCAN	7,134	1,049	18,980	0	887	57.00
58.00	05800	MRI	3,881	1,237	22,388	0	1,046	58.00
59.00	05900	CARDIAC CATHETERIZATION	13,152	1,194	21,621	0	1,010	59.00
60.00	06000	LABORATORY	40,090	4,548	82,319	269	3,847	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	16,019	497	8,996	0	420	65.00
66.00	06600	PHYSICAL THERAPY	23,427	3,001	54,325	30	2,539	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,377	779	14,099	0	659	67.00
68.00	06800	SPEECH PATHOLOGY	3,376	2,854	51,651	0	2,414	68.00
69.00	06900	ELECTROCARDIOLOGY	5,253	199	3,604	0	168	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,394	418	7,573	0	354	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	44,342	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	44,842	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	8,185	0	0	0	0	73.00
73.01	07301	OUTPATIENT PHARMACY	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	LITHOTRIPSY	0	0	0	0	0	76.00
76.01	03951	CARDIAC REHABILITATION	2,322	1,699	30,745	0	1,437	76.01
76.02	03020	GASTROINTESTINAL SERVICES	12,683	1,642	29,723	0	1,389	76.02
76.03	03030	ANGIOCARDIOGRAPHY	0	0	0	0	0	76.03
76.05	03954	INPATIENT RENAL DIALYSIS	0	0	0	0	0	76.05
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	132	0	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES	0	0	0	0	0	90.01
90.02	04950	WOUND CARE	7,567	1,051	19,031	0	889	90.02
90.03	09003	RIVER FOREST	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	47,066	4,700	85,079	120	3,976	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	827,453	135,443	1,744,566	39,311	80,459	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,752	1,812	32,807	0	1,533	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	NON-EMPLOYEE CHILD CARE CENTER	0	0	0	0	0	192.01
192.02	19202	OUTPATIENT PHARMACY	16,874	1,453	26,298	0	1,229	192.02
192.03	19203	WEST TOWN PHO	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	537	1,000	18,094	0	846	193.00
193.01	19301	ADULT DAY CARE	1,816	744	13,460	0	629	193.01
194.00	07950	DISCONTINUED HOME HEALTH AND HOSPICE	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	848,432	140,452	1,835,225	39,311	84,696	202.00

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Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	224,165					10.00
11.00	01100	CAFETERIA	100,289	315,042				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	6,579	0	97,208		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	13,031	0	82	454,695	14.00
15.00	01500	PHARMACY	0	12,793	0	0	5,676	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	456	0	34	123	16.00
17.00	01700	SOCIAL SERVICE	0	4,668	0	0	10	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	44	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	39,551	70,785	0	37,578	1,551	30.00
31.00	03100	INTENSIVE CARE UNIT	7,441	18,684	0	11,747	598	31.00
40.00	04000	SUBPROVIDER - IPF	6,045	9,653	0	4,001	86	40.00
41.00	04100	SUBPROVIDER - IRF	10,458	14,876	0	7,222	476	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	14,389	18,188	0	7,848	476	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	20,813	0	7,071	15,584	50.00
51.00	05100	RECOVERY ROOM	0	2,393	0	1,443	37	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	280	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	13,071	0	696	268	54.00
56.00	05600	RADIOISOTOPE	0	979	0	0	23	56.00
56.01	03630	ULTRASOUND	0	2,962	0	0	73	56.01
57.00	05700	CT SCAN	0	3,055	0	0	574	57.00
58.00	05800	MRI	0	1,111	0	0	38	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	3,035	0	511	1,357	59.00
60.00	06000	LABORATORY	0	21,765	0	0	58,333	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	9,210	0	0	2,066	65.00
66.00	06600	PHYSICAL THERAPY	0	15,240	0	193	46	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,732	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,765	0	0	8	68.00
69.00	06900	ELECTROCARDIOLOGY	0	3,008	0	210	92	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	919	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	194,111	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	169,006	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	OUTPATIENT PHARMACY	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	LITHOTRIPSY	0	0	0	0	0	76.00
76.01	03951	CARDIAC REHABILITATION	0	1,124	0	266	28	76.01
76.02	03020	GASTROINTESTINAL SERVICES	0	5,977	0	2,808	871	76.02
76.03	03030	ANGIOCARDIOGRAPHY	0	0	0	0	0	76.03
76.05	03954	INPATIENT RENAL DIALYSIS	0	0	0	0	0	76.05
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	5,362	0	2,610	0	90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES	0	0	0	0	0	90.01
90.02	04950	WOUND CARE	0	231	0	150	658	90.02
90.03	09003	RIVER FOREST	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	27,279	0	12,515	862	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description		DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
		10.00	11.00	12.00	13.00	14.00	
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	178,173	310,744	0	96,985	453,355	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	443	0	0	40	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	45,992	0	0	0	0	192.00
192.01	19201 NON-EMPLOYEE CHILD CARE CENTER	0	0	0	0	0	192.01
192.02	19202 OUTPATIENT PHARMACY	0	2,592	0	0	1,191	192.02
192.03	19203 WEST TOWN PHO	0	0	0	0	0	192.03
193.00	19300 NONPAID WORKERS	0	0	0	0	70	193.00
193.01	19301 ADULT DAY CARE	0	1,263	0	223	32	193.01
194.00	07950 DISCONTINUED HOME HEALTH AND HOSPICE	0	0	0	0	7	194.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	224,165	315,042	0	97,208	454,695	202.00

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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
			15.00	16.00	17.00	19.00	20.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	414,914					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	40,354				16.00
17.00	01700	SOCIAL SERVICE	0	0	27,165			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
20.00	02000	NURSING SCHOOL	0	0	0		0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	6,514	13,739			30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,503	2,594			31.00
40.00	04000	SUBPROVIDER - IPF	0	710	2,120			40.00
41.00	04100	SUBPROVIDER - IRF	0	977	3,667			41.00
43.00	04300	NURSERY	0	0	0			43.00
44.00	04400	SKILLED NURSING FACILITY	0	1,157	5,045			44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	1,897	0			50.00
51.00	05100	RECOVERY ROOM	0	805	0			51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0			52.00
53.00	05300	ANESTHESIOLOGY	0	1,168	0			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,418	0			54.00
56.00	05600	RADIOISOTOPE	0	258	0			56.00
56.01	03630	ULTRASOUND	0	741	0			56.01
57.00	05700	CT SCAN	0	2,952	0			57.00
58.00	05800	MRI	0	774	0			58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,136	0			59.00
60.00	06000	LABORATORY	0	4,508	0			60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0			62.30
65.00	06500	RESPIRATORY THERAPY	0	797	0			65.00
66.00	06600	PHYSICAL THERAPY	0	1,295	0			66.00
67.00	06700	OCCUPATIONAL THERAPY	0	205	0			67.00
68.00	06800	SPEECH PATHOLOGY	0	81	0			68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,128	0			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	142	0			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	528	0			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	723	0			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	316,363	1,708	0			73.00
73.01	07301	OUTPATIENT PHARMACY	0	0	0			73.01
74.00	07400	RENAL DIALYSIS	0	0	0			74.00
76.00	03950	LITHOTRIPSY	0	0	0			76.00
76.01	03951	CARDIAC REHABILITATION	0	103	0			76.01
76.02	03020	GASTROINTESTINAL SERVICES	0	1,940	0			76.02
76.03	03030	ANGIOCARDIOGRAPHY	0	0	0			76.03
76.05	03954	INPATIENT RENAL DIALYSIS	0	0	0			76.05
76.97	07697	CARDIAC REHABILITATION	0	0	0			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0			76.98
76.99	07699	LITHOTRIPSY	0	0	0			76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	1	0			90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES	0	0	0			90.01
90.02	04950	WOUND CARE	0	326	0			90.02
90.03	09003	RIVER FOREST	0	0	0			90.03
91.00	09100	EMERGENCY	0	4,859	0			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0			99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0			99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0			99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0			99.40

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Cost Center Description		PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
		15.00	16.00	17.00	19.00	20.00	
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	316,363	40,354	27,165	0	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	67	0	0			190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0			192.00
192.01	19201 NON-EMPLOYEE CHILD CARE CENTER	0	0	0			192.01
192.02	19202 OUTPATIENT PHARMACY	98,482	0	0			192.02
192.03	19203 WEST TOWN PHO	0	0	0			192.03
193.00	19300 NONPAID WORKERS	0	0	0			193.00
193.01	19301 ADULT DAY CARE	0	0	0			193.01
194.00	07950 DISCONTINUED HOME HEALTH AND HOSPICE	2	0	0			194.00
200.00	Cross Foot Adjustments				0	0	200.00
201.00	Negative Cost Centers	0	0	0			201.00
202.00	TOTAL (sum lines 118 through 201)	414,914	40,354	27,165	0	0	202.00

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Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			SERVICES-SALAR Y & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
			21.00	22.00	23.00	24.00	25.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
20.00	02000	NURSING SCHOOL						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		3,185				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)			0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS				1,590,411	0	30.00
31.00	03100	INTENSIVE CARE UNIT				577,361	0	31.00
40.00	04000	SUBPROVIDER - IPF				190,704	0	40.00
41.00	04100	SUBPROVIDER - IRF				386,200	0	41.00
43.00	04300	NURSERY				0	0	43.00
44.00	04400	SKILLED NURSING FACILITY				425,112	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM				1,721,942	0	50.00
51.00	05100	RECOVERY ROOM				67,337	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM				0	0	52.00
53.00	05300	ANESTHESIOLOGY				159,941	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC				486,464	0	54.00
56.00	05600	RADIOISOTOPE				51,018	0	56.00
56.01	03630	ULTRASOUND				90,079	0	56.01
57.00	05700	CT SCAN				123,410	0	57.00
58.00	05800	MRI				218,499	0	58.00
59.00	05900	CARDIAC CATHETERIZATION				392,429	0	59.00
60.00	06000	LABORATORY				427,061	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS				0	0	62.30
65.00	06500	RESPIRATORY THERAPY				71,189	0	65.00
66.00	06600	PHYSICAL THERAPY				231,341	0	66.00
67.00	06700	OCCUPATIONAL THERAPY				53,104	0	67.00
68.00	06800	SPEECH PATHOLOGY				179,636	0	68.00
69.00	06900	ELECTROCARDIOLOGY				29,656	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY				36,210	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT				238,981	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS				214,571	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS				326,256	0	73.00
73.01	07301	OUTPATIENT PHARMACY				0	0	73.01
74.00	07400	RENAL DIALYSIS				0	0	74.00
76.00	03950	LITHOTRIPSY				0	0	76.00
76.01	03951	CARDIAC REHABILITATION				111,494	0	76.01
76.02	03020	GASTROINTESTINAL SERVICES				162,946	0	76.02
76.03	03030	ANGIOCARDIOGRAPHY				0	0	76.03
76.05	03954	INPATIENT RENAL DIALYSIS				0	0	76.05
76.97	07697	CARDIAC REHABILITATION				0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY				0	0	76.98
76.99	07699	LITHOTRIPSY				0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC				21,953	0	90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES				0	0	90.01
90.02	04950	WOUND CARE				72,012	0	90.02
90.03	09003	RIVER FOREST				0	0	90.03
91.00	09100	EMERGENCY				663,232	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0008

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description			INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			SERVICES-SALAR Y & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
			21.00	22.00	23.00	24.00	25.00	
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF				0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY				0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY				0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY				0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	9,320,549	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN				144,360	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES				45,992	0	192.00
192.01	19201	NON-EMPLOYEE CHILD CARE CENTER				0	0	192.01
192.02	19202	OUTPATIENT PHARMACY				207,760	0	192.02
192.03	19203	WEST TOWN PHO				0	0	192.03
193.00	19300	NONPAID WORKERS				60,518	0	193.00
193.01	19301	ADULT DAY CARE				48,393	0	193.01
194.00	07950	DISCONTINUED HOME HEALTH AND HOSPICE				9	0	194.00
200.00		Cross Foot Adjustments	0	3,185	0	3,185	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	3,185	0	9,830,766	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0008

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part II
Date/Time Prepared:
1/28/2021 3:56 pm

Cost Center Description			Total	
			26.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
6.00	00600	MAINTENANCE & REPAIRS		6.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
12.00	01200	MAINTENANCE OF PERSONNEL		12.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS		19.00
20.00	02000	NURSING SCHOOL		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)		23.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	1,590,411	30.00
31.00	03100	INTENSIVE CARE UNIT	577,361	31.00
40.00	04000	SUBPROVIDER - IPF	190,704	40.00
41.00	04100	SUBPROVIDER - IRF	386,200	41.00
43.00	04300	NURSERY	0	43.00
44.00	04400	SKILLED NURSING FACILITY	425,112	44.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	1,721,942	50.00
51.00	05100	RECOVERY ROOM	67,337	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	52.00
53.00	05300	ANESTHESIOLOGY	159,941	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	486,464	54.00
56.00	05600	RADIOISOTOPE	51,018	56.00
56.01	03630	ULTRASOUND	90,079	56.01
57.00	05700	CT SCAN	123,410	57.00
58.00	05800	MRI	218,499	58.00
59.00	05900	CARDIAC CATHETERIZATION	392,429	59.00
60.00	06000	LABORATORY	427,061	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	62.30
65.00	06500	RESPIRATORY THERAPY	71,189	65.00
66.00	06600	PHYSICAL THERAPY	231,341	66.00
67.00	06700	OCCUPATIONAL THERAPY	53,104	67.00
68.00	06800	SPEECH PATHOLOGY	179,636	68.00
69.00	06900	ELECTROCARDIOLOGY	29,656	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	36,210	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	238,981	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	214,571	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	326,256	73.00
73.01	07301	OUTPATIENT PHARMACY	0	73.01
74.00	07400	RENAL DIALYSIS	0	74.00
76.00	03950	LITHOTRIPSY	0	76.00
76.01	03951	CARDIAC REHABILITATION	111,494	76.01
76.02	03020	GASTROINTESTINAL SERVICES	162,946	76.02
76.03	03030	ANGIOCARDIOGRAPHY	0	76.03
76.05	03954	INPATIENT RENAL DIALYSIS	0	76.05
76.97	07697	CARDIAC REHABILITATION	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	76.98
76.99	07699	LITHOTRIPSY	0	76.99
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	21,953	90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES	0	90.01
90.02	04950	WOUND CARE	72,012	90.02
90.03	09003	RIVER FOREST	0	90.03
91.00	09100	EMERGENCY	663,232	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		92.00
OTHER REIMBURSABLE COST CENTERS				
99.10	09910	CORF	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	99.40
SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	9,320,549	118.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0008

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part II
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Cost Center Description		Total	
		26.00	
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	144,360
192.00	19200	PHYSICIANS' PRIVATE OFFICES	45,992
192.01	19201	NON-EMPLOYEE CHILD CARE CENTER	0
192.02	19202	OUTPATIENT PHARMACY	207,760
192.03	19203	WEST TOWN PHO	0
193.00	19300	NONPAID WORKERS	60,518
193.01	19301	ADULT DAY CARE	48,393
194.00	07950	DISCONTINUED HOME HEALTH AND HOSPICE	9
200.00		Cross Foot Adjustments	3,185
201.00		Negative Cost Centers	0
202.00		TOTAL (sum lines 118 through 201)	9,830,766

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0008

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

Worksheet B-1

Date/Time Prepared:
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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	337,493					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		8,856,428				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	8,928	32,479	45,357,443			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	27,965	791,248	2,833,795	-24,201,687	88,868,789	5.00
6.00	00600	MAINTENANCE & REPAIRS	2,176	176,253	863,501	0	2,808,481	6.00
7.00	00700	OPERATION OF PLANT	82,996	440,848	751,786	0	6,083,062	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,368	0	0	0	132,876	8.00
9.00	00900	HOUSEKEEPING	1,316	2,682	1,343,365	0	3,553,885	9.00
10.00	01000	DIETARY	6,921	28,271	404,627	0	675,947	10.00
11.00	01100	CAFETERIA	6,278	53,235	759,954	0	1,437,901	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	1,657	59,666	1,277,402	0	1,602,081	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	8,951	426,132	1,037,850	0	1,822,913	14.00
15.00	01500	PHARMACY	3,087	663,492	1,992,897	0	4,236,239	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,400	0	0	0	26,346	16.00
17.00	01700	SOCIAL SERVICE	587	0	541,321	0	394,989	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	328,980	22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	41,625	268,588	8,250,621	0	11,315,199	30.00
31.00	03100	INTENSIVE CARE UNIT	10,707	411,789	2,964,351	0	4,237,008	31.00
40.00	04000	SUBPROVIDER - IPF	5,305	2,145	1,060,476	0	1,360,277	40.00
41.00	04100	SUBPROVIDER - IRF	10,117	81,270	1,796,839	0	2,507,246	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	11,448	39,409	1,972,687	0	3,326,051	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	27,116	2,124,913	2,720,415	0	6,770,948	50.00
51.00	05100	RECOVERY ROOM	674	93,177	413,394	0	564,747	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	617	350,498	0	0	354,633	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,834	419,217	1,607,360	0	2,358,532	54.00
56.00	05600	RADIOISOTOPE	1,608	750	163,913	0	361,722	56.00
56.01	03630	ULTRASOUND	1,331	103,667	486,004	0	638,302	56.01
57.00	05700	CT SCAN	2,228	114,437	474,407	0	747,207	57.00
58.00	05800	MRI	2,628	351,043	163,080	0	406,542	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,538	761,589	611,262	0	1,377,607	59.00
60.00	06000	LABORATORY	9,663	53,332	2,152,968	0	4,199,205	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,056	22,239	1,147,529	0	1,677,912	65.00
66.00	06600	PHYSICAL THERAPY	6,377	8,511	1,980,280	0	2,453,871	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,655	0	277,975	0	353,724	67.00
68.00	06800	SPEECH PATHOLOGY	6,063	6,660	193,546	0	353,585	68.00
69.00	06900	ELECTROCARDIOLOGY	423	16,841	355,481	0	550,245	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	889	21,193	88,730	0	145,989	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	4,644,580	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	4,696,984	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	857,384	73.00
73.01	07301	OUTPATIENT PHARMACY	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	LITHOTRIPSY	0	0	0	0	0	76.00
76.01	03951	CARDIAC REHABILITATION	3,609	13,429	144,669	0	243,249	76.01
76.02	03020	GASTROINTESTINAL SERVICES	3,489	94,772	757,645	0	1,328,454	76.02
76.03	03030	ANGIOCARDIOGRAPHY	0	0	0	0	0	76.03
76.05	03954	INPATIENT RENAL DIALYSIS	0	0	0	0	0	76.05
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	35,246	0	0	13,848	90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES	0	0	0	0	0	90.01
90.02	04950	WOUND CARE	2,234	0	17,133	0	792,633	90.02
90.03	09003	RIVER FOREST	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	9,987	702,543	3,215,247	0	4,929,967	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0008

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

Worksheet B-1

Date/Time Prepared:
1/28/2021 3:56 pm

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP ((DOLLAR VALUE))				
		1.00	2.00	4.00	5A	5.00	
OTHER REIMBURSABLE COST CENTERS							
99.10	09910 CORF	0	0	0	0	0	99.10
99.20	09920 OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930 OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940 OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	326,851	8,771,564	44,822,510	-24,201,687	86,671,351	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,851	84,864	23,334	0	183,529	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201 NON-EMPLOYEE CHILD CARE CENTER	0	0	0	0	0	192.01
192.02	19202 OUTPATIENT PHARMACY	3,087	0	388,201	0	1,767,450	192.02
192.03	19203 WEST TOWN PHO	0	0	0	0	0	192.03
193.00	19300 NONPAID WORKERS	2,124	0	0	0	56,253	193.00
193.01	19301 ADULT DAY CARE	1,580	0	123,398	0	190,206	193.01
194.00	07950 DISCONTINUED HOME HEALTH AND HOSPICE	0	0	0	0	0	194.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	6,351,233	3,479,533	339,926		24,201,687	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	18.818858	0.392882	0.007494		0.272331	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			180,775		848,432	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.003986		0.009547	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: 14-0008

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

Worksheet B-1

Date/Time Prepared:
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Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY))	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED))	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS	298,424				6.00
7.00	00700	OPERATION OF PLANT	82,996	215,428			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,368	1,368	642,368		8.00
9.00	00900	HOUSEKEEPING	1,316	1,316	126,844	212,744	9.00
10.00	01000	DIETARY	6,921	6,921	159,725	6,921	363,501
11.00	01100	CAFETERIA	6,278	6,278	0	6,278	162,625
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	1,657	1,657	1,000	1,657	0
14.00	01400	CENTRAL SERVICES & SUPPLY	8,951	8,951	2,349	8,951	0
15.00	01500	PHARMACY	3,087	3,087	5,066	3,087	0
16.00	01600	MEDICAL RECORDS & LIBRARY	1,400	1,400	0	1,400	0
17.00	01700	SOCIAL SERVICE	587	587	0	587	0
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
20.00	02000	NURSING SCHOOL	0	0	0	0	0
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	41,625	41,625	2,944	41,625	64,135
31.00	03100	INTENSIVE CARE UNIT	10,707	10,707	306,109	10,707	12,066
40.00	04000	SUBPROVIDER - IPF	5,305	5,305	6,475	5,305	9,803
41.00	04100	SUBPROVIDER - IRF	10,117	10,117	2,112	10,117	16,959
43.00	04300	NURSERY	0	0	0	0	0
44.00	04400	SKILLED NURSING FACILITY	11,448	11,448	0	11,448	23,333
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	27,116	27,116	22,901	27,116	0
51.00	05100	RECOVERY ROOM	674	674	0	674	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0
53.00	05300	ANESTHESIOLOGY	617	617	0	617	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,834	9,834	0	9,834	0
56.00	05600	RADIOISOTOPE	1,608	1,608	0	1,608	0
56.01	03630	ULTRASOUND	1,331	1,331	0	1,331	0
57.00	05700	CT SCAN	2,228	2,228	0	2,228	0
58.00	05800	MRI	2,628	2,628	0	2,628	0
59.00	05900	CARDIAC CATHETERIZATION	2,538	2,538	0	2,538	0
60.00	06000	LABORATORY	9,663	9,663	4,393	9,663	0
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	1,056	1,056	0	1,056	0
66.00	06600	PHYSICAL THERAPY	6,377	6,377	484	6,377	0
67.00	06700	OCCUPATIONAL THERAPY	1,655	1,655	0	1,655	0
68.00	06800	SPEECH PATHOLOGY	6,063	6,063	0	6,063	0
69.00	06900	ELECTROCARDIOLOGY	423	423	0	423	0
70.00	07000	ELECTROENCEPHALOGRAPHY	889	889	0	889	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
73.01	07301	OUTPATIENT PHARMACY	0	0	0	0	0
74.00	07400	RENAL DIALYSIS	0	0	0	0	0
76.00	03950	LITHOTRIPSY	0	0	0	0	0
76.01	03951	CARDIAC REHABILITATION	3,609	3,609	0	3,609	0
76.02	03020	GASTROINTESTINAL SERVICES	3,489	3,489	0	3,489	0
76.03	03030	ANGIOCARDIOGRAPHY	0	0	0	0	0
76.05	03954	INPATIENT RENAL DIALYSIS	0	0	0	0	0
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0
76.99	07699	LITHOTRIPSY	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0
90.01	09001	OUTPATIENT INFUSION PROCEDURES	0	0	0	0	0
90.02	04950	WOUND CARE	2,234	2,234	0	2,234	0
90.03	09003	RIVER FOREST	0	0	0	0	0
91.00	09100	EMERGENCY	9,987	9,987	1,966	9,987	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	0
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0008

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

Worksheet B-1

Date/Time Prepared:
1/28/2021 3:56 pm

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE ((POUNDS OF LAUNDRY))	HOUSEKEEPING (SQUARE FEET)	DIETARY ((MEALS SERVED))	
		6.00	7.00	8.00	9.00	10.00	
99.40	09940 OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
	SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	287,782	204,786	642,368	202,102	288,921	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,851	3,851	0	3,851	0	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	74,580	192.00
192.01	19201 NON-EMPLOYEE CHILD CARE CENTER	0	0	0	0	0	192.01
192.02	19202 OUTPATIENT PHARMACY	3,087	3,087	0	3,087	0	192.02
192.03	19203 WEST TOWN PHO	0	0	0	0	0	192.03
193.00	19300 NONPAID WORKERS	2,124	2,124	0	2,124	0	193.00
193.01	19301 ADULT DAY CARE	1,580	1,580	0	1,580	0	193.01
194.00	07950 DISCONTINUED HOME HEALTH AND HOSPICE	0	0	0	0	0	194.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	3,573,317	8,733,455	240,901	4,638,396	1,434,274	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	11.973960	40.540018	0.375020	21.802711	3.945722	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	140,452	1,835,225	39,311	84,696	224,165	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.470646	8.518972	0.061197	0.398112	0.616683	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: 14-0008

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

Worksheet B-1

Date/Time Prepared:
1/28/2021 3:56 pm

Cost Center Description			CAFETERIA ((FTE SERVED))	MAINTENANCE OF PERSONNEL ((FTE SERVED))	NURSING ADMINISTRATION ((FTE SERVED))	CENTRAL SERVICES & SUPPLY ((COSTED REQUIS))	PHARMACY ((COSTED REQUIS))	
			11.00	12.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	47,650					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	995	0	22,641			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,971	0	19	2,913,446		14.00
15.00	01500	PHARMACY	1,935	0	0	36,366	5,460,861	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	69	0	8	789	0	16.00
17.00	01700	SOCIAL SERVICE	706	0	0	64	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	280	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	10,706	0	8,752	9,941	0	30.00
31.00	03100	INTENSIVE CARE UNIT	2,826	0	2,736	3,833	0	31.00
40.00	04000	SUBPROVIDER - IPF	1,460	0	932	552	0	40.00
41.00	04100	SUBPROVIDER - IRF	2,250	0	1,682	3,048	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	2,751	0	1,828	3,047	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	3,148	0	1,647	99,854	0	50.00
51.00	05100	RECOVERY ROOM	362	0	336	238	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	1,791	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,977	0	162	1,716	0	54.00
56.00	05600	RADIOISOTOPE	148	0	0	147	0	56.00
56.01	03630	ULTRASOUND	448	0	0	467	0	56.01
57.00	05700	CT SCAN	462	0	0	3,679	0	57.00
58.00	05800	MRI	168	0	0	246	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	459	0	119	8,698	0	59.00
60.00	06000	LABORATORY	3,292	0	0	373,767	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,393	0	0	13,239	0	65.00
66.00	06600	PHYSICAL THERAPY	2,305	0	45	295	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	262	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	267	0	0	49	0	68.00
69.00	06900	ELECTROCARDIOLOGY	455	0	49	590	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	139	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	1,243,765	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,082,897	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	4,163,798	73.00
73.01	07301	OUTPATIENT PHARMACY	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	LITHOTRIPSY	0	0	0	0	0	76.00
76.01	03951	CARDIAC REHABILITATION	170	0	62	177	0	76.01
76.02	03020	GASTROINTESTINAL SERVICES	904	0	654	5,584	0	76.02
76.03	03030	ANGIOCARDIOGRAPHY	0	0	0	0	0	76.03
76.05	03954	INPATIENT RENAL DIALYSIS	0	0	0	0	0	76.05
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	811	0	608	0	0	90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES	0	0	0	0	0	90.01
90.02	04950	WOUND CARE	35	0	35	4,218	0	90.02
90.03	09003	RIVER FOREST	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	4,126	0	2,915	5,521	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0008

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

Worksheet B-1

Date/Time Prepared:
1/28/2021 3:56 pm

Cost Center Description			CAFETERIA ((FTES SERVED))	MAINTENANCE OF PERSONNEL ((FTES SERVED))	NURSING ADMINISTRATION ((FTES SERVED))	CENTRAL SERVICES & SUPPLY ((COSTED REQUIS))	PHARMACY ((COSTED REQUIS))	
			11.00	12.00	13.00	14.00	15.00	
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	47,000	0	22,589	2,904,858	4,163,798	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	67	0	0	255	883	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	NON-EMPLOYEE CHILD CARE CENTER	0	0	0	0	0	192.01
192.02	19202	OUTPATIENT PHARMACY	392	0	0	7,631	1,296,160	192.02
192.03	19203	WEST TOWN PHO	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	447	0	193.00
193.01	19301	ADULT DAY CARE	191	0	52	208	0	193.01
194.00	07950	DISCONTINUED HOME HEALTH AND HOSPICE	0	0	0	47	20	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,937,719	0	2,223,239	3,108,821	5,779,316	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	61.652025	0.000000	98.195265	1.067060	1.058316	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	315,042	0	97,208	454,695	414,914	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	6.611584	0.000000	4.293450	0.156068	0.075980	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: 14-0008

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

Worksheet B-1

Date/Time Prepared:
1/28/2021 3:56 pm

Cost Center Description			MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALAR Y & FRINGES APPRV ((ASSIGNED TIME))	
			16.00	17.00	19.00	20.00	21.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	563,981,417					16.00
17.00	01700	SOCIAL SERVICE	0	38,206				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
20.00	02000	NURSING SCHOOL	0	0		0		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0			100	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0				22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0				23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	93,956,968	19,324	0	0		30.00
31.00	03100	INTENSIVE CARE UNIT	20,869,109	3,649	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	9,858,167	2,981	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	13,562,910	5,157	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	16,066,636	7,095	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	26,341,591	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	11,179,607	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	16,223,983	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	19,700,844	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	3,588,819	0	0	0	0	56.00
56.01	03630	ULTRASOUND	10,298,061	0	0	0	0	56.01
57.00	05700	CT SCAN	40,998,143	0	0	0	0	57.00
58.00	05800	MRI	10,756,667	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	15,778,880	0	0	0	0	59.00
60.00	06000	LABORATORY	62,612,733	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	11,067,297	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	17,992,302	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,853,554	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,125,130	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	15,667,417	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,969,898	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,335,600	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,042,043	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	23,720,101	0	0	0	0	73.00
73.01	07301	OUTPATIENT PHARMACY	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	LITHOTRIPSY	0	0	0	0	0	76.00
76.01	03951	CARDIAC REHABILITATION	1,431,960	0	0	0	0	76.01
76.02	03020	GASTROINTESTINAL SERVICES	26,949,120	0	0	0	0	76.02
76.03	03030	ANGIOCARDIOGRAPHY	0	0	0	0	0	76.03
76.05	03954	INPATIENT RENAL DIALYSIS	0	0	0	0	0	76.05
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	16,197	0	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES	0	0	0	0	0	90.01
90.02	04950	WOUND CARE	4,528,397	0	0	0	0	90.02
90.03	09003	RIVER FOREST	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	67,489,283	0	0	0	99	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0008

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

Worksheet B-1

Date/Time Prepared:
1/28/2021 3:56 pm

Cost Center Description		MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALAR Y & FRINGES APPRV ((ASSIGNED TIME))	
		16.00	17.00	19.00	20.00	21.00	
OTHER REIMBURSABLE COST CENTERS							
99.10	09910 CORF	0	0	0	0	0	99.10
99.20	09920 OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930 OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940 OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	563,981,417	38,206	0	0	100	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201 NON-EMPLOYEE CHILD CARE CENTER	0	0	0	0	0	192.01
192.02	19202 OUTPATIENT PHARMACY	0	0	0	0	0	192.02
192.03	19203 WEST TOWN PHO	0	0	0	0	0	192.03
193.00	19300 NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301 ADULT DAY CARE	0	0	0	0	0	193.01
194.00	07950 DISCONTINUED HOME HEALTH AND HOSPICE	0	0	0	0	0	194.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	143,447	589,775	0	0	0	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.000254	15.436712	0.000000	0.000000	0.000000	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	40,354	27,165	0	0	0	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000072	0.711014	0.000000	0.000000	0.000000	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)				0		206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)				0.000000		207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0008

Period:
From 07/01/2019
To 06/30/2020Worksheet B-1
Date/Time Prepared:
1/28/2021 3:56 pm

Cost Center Description			INTERNS & RESIDENTS	PARAMED ED PRGM (ASSIGNED TIME)	
			SERVICES-OTHER PRGM COSTS APPRV ((ASSIGNED TIME))		
			22.00		
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
6.00	00600	MAINTENANCE & REPAIRS			6.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
12.00	01200	MAINTENANCE OF PERSONNEL			12.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS			19.00
20.00	02000	NURSING SCHOOL			20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	100		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)		0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	1	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	41.00
43.00	04300	NURSERY	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	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
56.00	05600	RADIOISOTOPE	0	0	56.00
56.01	03630	ULTRASOUND	0	0	56.01
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
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
73.01	07301	OUTPATIENT PHARMACY	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	74.00
76.00	03950	LITHOTRIPSY	0	0	76.00
76.01	03951	CARDIAC REHABILITATION	0	0	76.01
76.02	03020	GASTROINTESTINAL SERVICES	0	0	76.02
76.03	03030	ANGIOCARDIOGRAPHY	0	0	76.03
76.05	03954	INPATIENT RENAL DIALYSIS	0	0	76.05
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0	90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES	0	0	90.01
90.02	04950	WOUND CARE	0	0	90.02
90.03	09003	RIVER FOREST	0	0	90.03
91.00	09100	EMERGENCY	99	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0008

Period:
From 07/01/2019
To 06/30/2020Worksheet B-1
Date/Time Prepared:
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Cost Center Description		INTERNS & RESIDENTS	PARAMED ED PRGM (ASSIGNED TIME)		
		SERVICES-OTHER			
		PRGM COSTS APPRV ((ASSIGNED TIME))			
		22.00			
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	99.40
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	100	0	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
192.01	19201	NON-EMPLOYEE CHILD CARE CENTER	0	0	192.01
192.02	19202	OUTPATIENT PHARMACY	0	0	192.02
192.03	19203	WEST TOWN PHO	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	193.00
193.01	19301	ADULT DAY CARE	0	0	193.01
194.00	07950	DISCONTINUED HOME HEALTH AND HOSPICE	0	0	194.00
200.00		Cross Foot Adjustments			200.00
201.00		Negative Cost Centers			201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	418,870	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	4,188.700000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	3,185	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	31.850000	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)		0	206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)		0.000000	207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0008

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
1/28/2021 3:56 pm

			Title XVIII		Hospital		PPS
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		
					Total Costs	RCE Disallowance	Total Costs
			1.00	2.00	3.00	4.00	5.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	19,596,651		19,596,651	0	19,596,651
31.00	03100	INTENSIVE CARE UNIT	6,857,604		6,857,604	0	6,857,604
40.00	04000	SUBPROVIDER - IPF	2,396,721		2,396,721	0	2,396,721
41.00	04100	SUBPROVIDER - IRF	4,399,801		4,399,801	0	4,399,801
43.00	04300	NURSERY	0		0	0	0
44.00	04400	SKILLED NURSING FACILITY	5,640,642		5,640,642	0	5,640,642
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	11,107,696		11,107,696	0	11,107,696
51.00	05100	RECOVERY ROOM	827,040		827,040	0	827,040
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0
53.00	05300	ANESTHESIOLOGY	503,096		503,096	0	503,096
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,876,293		3,876,293	0	3,876,293
56.00	05600	RADIOISOTOPE	589,924		589,924	0	589,924
56.01	03630	ULTRASOUND	941,780		941,780	0	941,780
57.00	05700	CT SCAN	1,159,095		1,159,095	0	1,159,095
58.00	05800	MRI	725,913		725,913	0	725,913
59.00	05900	CARDIAC CATHETERIZATION	1,994,660		1,994,660	0	1,994,660
60.00	06000	LABORATORY	6,680,242		6,680,242	0	6,680,242
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0
65.00	06500	RESPIRATORY THERAPY	2,316,157	0	2,316,157	0	2,316,157
66.00	06600	PHYSICAL THERAPY	3,747,648	0	3,747,648	0	3,747,648
67.00	06700	OCCUPATIONAL THERAPY	589,926	0	589,926	0	589,926
68.00	06800	SPEECH PATHOLOGY	917,258	0	917,258	0	917,258
69.00	06900	ELECTROCARDIOLOGY	769,004		769,004	0	769,004
70.00	07000	ELECTROENCEPHALOGRAPHY	260,884		260,884	0	260,884
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,238,478		7,238,478	0	7,238,478
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,134,185		7,134,185	0	7,134,185
73.00	07300	DRUGS CHARGED TO PATIENTS	5,503,515		5,503,515	0	5,503,515
73.01	07301	OUTPATIENT PHARMACY	0		0	0	0
74.00	07400	RENAL DIALYSIS	0		0	0	0
76.00	03950	LITHOTRIPSY	0		0	0	0
76.01	03951	CARDIAC REHABILITATION	594,824		594,824	0	594,824
76.02	03020	GASTROINTESTINAL SERVICES	2,082,280		2,082,280	0	2,082,280
76.03	03030	ANGIOCARDIOGRAPHY	0		0	0	0
76.05	03954	INPATIENT RENAL DIALYSIS	0		0	0	0
76.97	07697	CARDIAC REHABILITATION	0		0	0	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0
76.99	07699	LITHOTRIPSY	0		0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	127,326		127,326	0	127,326
90.01	09001	OUTPATIENT INFUSION PROCEDURES	0		0	0	0
90.02	04950	WOUND CARE	1,185,761		1,185,761	0	1,185,761
90.03	09003	RIVER FOREST	0		0	0	0
91.00	09100	EMERGENCY	7,579,136		7,579,136	0	7,579,136
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,437,478		2,437,478	0	2,437,478
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0		0	0	0
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0		0	0	0
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0		0	0	0
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0		0	0	0
200.00		Subtotal (see instructions)	109,781,018	0	109,781,018	0	109,781,018
201.00		Less Observation Beds	2,437,478		2,437,478	0	2,437,478
202.00		Total (see instructions)	107,343,540	0	107,343,540	0	107,343,540

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0008

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
1/28/2021 3:56 pm

			Title XVIII		Hospital		PPS
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	77,270,126		77,270,126		30.00
31.00	03100	INTENSIVE CARE UNIT	20,869,109		20,869,109		31.00
40.00	04000	SUBPROVIDER - IPF	9,858,167		9,858,167		40.00
41.00	04100	SUBPROVIDER - IRF	13,562,910		13,562,910		41.00
43.00	04300	NURSERY	0		0		43.00
44.00	04400	SKILLED NURSING FACILITY	16,066,636		16,066,636		44.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	8,828,242	17,513,349	26,341,591	0.421679	0.000000
51.00	05100	RECOVERY ROOM	4,380,846	6,798,761	11,179,607	0.073978	0.000000
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000
53.00	05300	ANESTHESIOLOGY	6,431,339	9,792,644	16,223,983	0.031009	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,780,502	14,920,342	19,700,844	0.196758	0.000000
56.00	05600	RADIOISOTOPE	1,057,435	2,531,384	3,588,819	0.164378	0.000000
56.01	03630	ULTRASOUND	2,464,864	7,833,197	10,298,061	0.091452	0.000000
57.00	05700	CT SCAN	11,064,457	29,933,686	40,998,143	0.028272	0.000000
58.00	05800	MRI	2,161,744	8,594,923	10,756,667	0.067485	0.000000
59.00	05900	CARDIAC CATHETERIZATION	9,908,807	5,870,073	15,778,880	0.126413	0.000000
60.00	06000	LABORATORY	28,609,104	34,003,629	62,612,733	0.106691	0.000000
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000
65.00	06500	RESPIRATORY THERAPY	10,228,376	838,921	11,067,297	0.209279	0.000000
66.00	06600	PHYSICAL THERAPY	12,218,584	5,773,718	17,992,302	0.208292	0.000000
67.00	06700	OCCUPATIONAL THERAPY	2,051,952	801,602	2,853,554	0.206734	0.000000
68.00	06800	SPEECH PATHOLOGY	669,870	455,260	1,125,130	0.815246	0.000000
69.00	06900	ELECTROCARDIOLOGY	6,827,968	8,839,449	15,667,417	0.049083	0.000000
70.00	07000	ELECTROENCEPHALOGRAPHY	234,458	1,735,440	1,969,898	0.132435	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,129,150	3,206,450	7,335,600	0.986760	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,803,129	3,238,914	10,042,043	0.710432	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	15,667,540	8,052,561	23,720,101	0.232019	0.000000
73.01	07301	OUTPATIENT PHARMACY	0	0	0	0.000000	0.000000
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000
76.00	03950	LITHOTRIPSY	0	0	0	0.000000	0.000000
76.01	03951	CARDIAC REHABILITATION	1,056	1,430,904	1,431,960	0.415391	0.000000
76.02	03020	GASTROINTESTINAL SERVICES	2,913,324	24,035,796	26,949,120	0.077267	0.000000
76.03	03030	ANGIOCARDIOGRAPHY	0	0	0	0.000000	0.000000
76.05	03954	INPATIENT RENAL DIALYSIS	0	0	0	0.000000	0.000000
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	267	15,930	16,197	7.861085	0.000000
90.01	09001	OUTPATIENT INFUSION PROCEDURES	0	0	0	0.000000	0.000000
90.02	04950	WOUND CARE	12,866	4,515,531	4,528,397	0.261850	0.000000
90.03	09003	RIVER FOREST	0	0	0	0.000000	0.000000
91.00	09100	EMERGENCY	16,291,987	51,197,296	67,489,283	0.112301	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	6,532,190	10,154,652	16,686,842	0.146072	0.000000
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0		99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0		99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0		99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0		99.40
200.00		Subtotal (see instructions)	301,897,005	262,084,412	563,981,417		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	301,897,005	262,084,412	563,981,417		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0008

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
1/28/2021 3:56 pm

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
41.00	04100	SUBPROVIDER - IRF			41.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.421679		50.00
51.00	05100	RECOVERY ROOM	0.073978		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.031009		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.196758		54.00
56.00	05600	RADIOISOTOPE	0.164378		56.00
56.01	03630	ULTRASOUND	0.091452		56.01
57.00	05700	CT SCAN	0.028272		57.00
58.00	05800	MRI	0.067485		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.126413		59.00
60.00	06000	LABORATORY	0.106691		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000		62.30
65.00	06500	RESPIRATORY THERAPY	0.209279		65.00
66.00	06600	PHYSICAL THERAPY	0.208292		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.206734		67.00
68.00	06800	SPEECH PATHOLOGY	0.815246		68.00
69.00	06900	ELECTROCARDIOLOGY	0.049083		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.132435		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.986760		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.710432		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.232019		73.00
73.01	07301	OUTPATIENT PHARMACY	0.000000		73.01
74.00	07400	RENAL DIALYSIS	0.000000		74.00
76.00	03950	LITHOTRIPSY	0.000000		76.00
76.01	03951	CARDIAC REHABILITATION	0.415391		76.01
76.02	03020	GASTROINTESTINAL SERVICES	0.077267		76.02
76.03	03030	ANGIOCARDIOGRAPHY	0.000000		76.03
76.05	03954	INPATIENT RENAL DIALYSIS	0.000000		76.05
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000		76.98
76.99	07699	LITHOTRIPSY	0.000000		76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	7.861085		90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES	0.000000		90.01
90.02	04950	WOUND CARE	0.261850		90.02
90.03	09003	RIVER FOREST	0.000000		90.03
91.00	09100	EMERGENCY	0.112301		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.146072		92.00
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF			99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY			99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY			99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY			99.40
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0008

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
1/28/2021 3:56 pm

				Title XIX		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
					Total Costs	RCE Disallowance	Total Costs		
			1.00	2.00	3.00	4.00	5.00		
	INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	19,596,651		19,596,651	0	19,596,651	30.00	
31.00	03100	INTENSIVE CARE UNIT	6,857,604		6,857,604	0	6,857,604	31.00	
40.00	04000	SUBPROVIDER - IPF	2,396,721		2,396,721	0	2,396,721	40.00	
41.00	04100	SUBPROVIDER - IRF	4,399,801		4,399,801	0	4,399,801	41.00	
43.00	04300	NURSERY	0		0	0	0	43.00	
44.00	04400	SKILLED NURSING FACILITY	5,640,642		5,640,642	0	5,640,642	44.00	
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	11,107,696		11,107,696	0	11,107,696	50.00	
51.00	05100	RECOVERY ROOM	827,040		827,040	0	827,040	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00	
53.00	05300	ANESTHESIOLOGY	503,096		503,096	0	503,096	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,876,293		3,876,293	0	3,876,293	54.00	
56.00	05600	RADIOISOTOPE	589,924		589,924	0	589,924	56.00	
56.01	03630	ULTRASOUND	941,780		941,780	0	941,780	56.01	
57.00	05700	CT SCAN	1,159,095		1,159,095	0	1,159,095	57.00	
58.00	05800	MRI	725,913		725,913	0	725,913	58.00	
59.00	05900	CARDIAC CATHETERIZATION	1,994,660		1,994,660	0	1,994,660	59.00	
60.00	06000	LABORATORY	6,680,242		6,680,242	0	6,680,242	60.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30	
65.00	06500	RESPIRATORY THERAPY	2,316,157	0	2,316,157	0	2,316,157	65.00	
66.00	06600	PHYSICAL THERAPY	3,747,648	0	3,747,648	0	3,747,648	66.00	
67.00	06700	OCCUPATIONAL THERAPY	589,926	0	589,926	0	589,926	67.00	
68.00	06800	SPEECH PATHOLOGY	917,258	0	917,258	0	917,258	68.00	
69.00	06900	ELECTROCARDIOLOGY	769,004		769,004	0	769,004	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	260,884		260,884	0	260,884	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,238,478		7,238,478	0	7,238,478	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,134,185		7,134,185	0	7,134,185	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	5,503,515		5,503,515	0	5,503,515	73.00	
73.01	07301	OUTPATIENT PHARMACY	0		0	0	0	73.01	
74.00	07400	RENAL DIALYSIS	0		0	0	0	74.00	
76.00	03950	LITHOTRIPSY	0		0	0	0	76.00	
76.01	03951	CARDIAC REHABILITATION	594,824		594,824	0	594,824	76.01	
76.02	03020	GASTROINTESTINAL SERVICES	2,082,280		2,082,280	0	2,082,280	76.02	
76.03	03030	ANGIOCARDIOGRAPHY	0		0	0	0	76.03	
76.05	03954	INPATIENT RENAL DIALYSIS	0		0	0	0	76.05	
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98	
76.99	07699	LITHOTRIPSY	0		0	0	0	76.99	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	127,326		127,326	0	127,326	90.00	
90.01	09001	OUTPATIENT INFUSION PROCEDURES	0		0	0	0	90.01	
90.02	04950	WOUND CARE	1,185,761		1,185,761	0	1,185,761	90.02	
90.03	09003	RIVER FOREST	0		0	0	0	90.03	
91.00	09100	EMERGENCY	7,579,136		7,579,136	0	7,579,136	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,437,478		2,437,478	0	2,437,478	92.00	
	OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0		0		0	99.10	
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0		0		0	99.20	
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0		0		0	99.30	
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0		0		0	99.40	
200.00		Subtotal (see instructions)	109,781,018	0	109,781,018	0	109,781,018	200.00	
201.00		Less Observation Beds	2,437,478		2,437,478	0	2,437,478	201.00	
202.00		Total (see instructions)	107,343,540	0	107,343,540	0	107,343,540	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0008

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
1/28/2021 3:56 pm

			Title XIX			Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
			Inpatient	Outpatient	Total (col. 6 + col. 7)			
			6.00	7.00	8.00			
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	77,270,126		77,270,126			30.00
31.00	03100	INTENSIVE CARE UNIT	20,869,109		20,869,109			31.00
40.00	04000	SUBPROVIDER - IPF	9,858,167		9,858,167			40.00
41.00	04100	SUBPROVIDER - IRF	13,562,910		13,562,910			41.00
43.00	04300	NURSERY	0		0			43.00
44.00	04400	SKILLED NURSING FACILITY	16,066,636		16,066,636			44.00
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	8,828,242	17,513,349	26,341,591	0.421679	0.000000	50.00
51.00	05100	RECOVERY ROOM	4,380,846	6,798,761	11,179,607	0.073978	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	6,431,339	9,792,644	16,223,983	0.031009	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,780,502	14,920,342	19,700,844	0.196758	0.000000	54.00
56.00	05600	RADIOISOTOPE	1,057,435	2,531,384	3,588,819	0.164378	0.000000	56.00
56.01	03630	ULTRASOUND	2,464,864	7,833,197	10,298,061	0.091452	0.000000	56.01
57.00	05700	CT SCAN	11,064,457	29,933,686	40,998,143	0.028272	0.000000	57.00
58.00	05800	MRI	2,161,744	8,594,923	10,756,667	0.067485	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	9,908,807	5,870,073	15,778,880	0.126413	0.000000	59.00
60.00	06000	LABORATORY	28,609,104	34,003,629	62,612,733	0.106691	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	10,228,376	838,921	11,067,297	0.209279	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	12,218,584	5,773,718	17,992,302	0.208292	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,051,952	801,602	2,853,554	0.206734	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	669,870	455,260	1,125,130	0.815246	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	6,827,968	8,839,449	15,667,417	0.049083	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	234,458	1,735,440	1,969,898	0.132435	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,129,150	3,206,450	7,335,600	0.986760	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	6,803,129	3,238,914	10,042,043	0.710432	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,667,540	8,052,561	23,720,101	0.232019	0.000000	73.00
73.01	07301	OUTPATIENT PHARMACY	0	0	0	0.000000	0.000000	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
76.00	03950	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.00
76.01	03951	CARDIAC REHABILITATION	1,056	1,430,904	1,431,960	0.415391	0.000000	76.01
76.02	03020	GASTROINTESTINAL SERVICES	2,913,324	24,035,796	26,949,120	0.077267	0.000000	76.02
76.03	03030	ANGIOCARDIOGRAPHY	0	0	0	0.000000	0.000000	76.03
76.05	03954	INPATIENT RENAL DIALYSIS	0	0	0	0.000000	0.000000	76.05
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	267	15,930	16,197	7.861085	0.000000	90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES	0	0	0	0.000000	0.000000	90.01
90.02	04950	WOUND CARE	12,866	4,515,531	4,528,397	0.261850	0.000000	90.02
90.03	09003	RIVER FOREST	0	0	0	0.000000	0.000000	90.03
91.00	09100	EMERGENCY	16,291,987	51,197,296	67,489,283	0.112301	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	6,532,190	10,154,652	16,686,842	0.146072	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0			99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0			99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0			99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0			99.40
200.00		Subtotal (see instructions)	301,897,005	262,084,412	563,981,417			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	301,897,005	262,084,412	563,981,417			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0008

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
1/28/2021 3:56 pm

Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital	Cost
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
41.00	04100	SUBPROVIDER - IRF			41.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
56.00	05600	RADIOISOTOPE	0.000000		56.00
56.01	03630	ULTRASOUND	0.000000		56.01
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MRI	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.000000		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000		62.30
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
73.01	07301	OUTPATIENT PHARMACY	0.000000		73.01
74.00	07400	RENAL DIALYSIS	0.000000		74.00
76.00	03950	LITHOTRIPSY	0.000000		76.00
76.01	03951	CARDIAC REHABILITATION	0.000000		76.01
76.02	03020	GASTROINTESTINAL SERVICES	0.000000		76.02
76.03	03030	ANGIOCARDIOGRAPHY	0.000000		76.03
76.05	03954	INPATIENT RENAL DIALYSIS	0.000000		76.05
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000		76.98
76.99	07699	LITHOTRIPSY	0.000000		76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES	0.000000		90.01
90.02	04950	WOUND CARE	0.000000		90.02
90.03	09003	RIVER FOREST	0.000000		90.03
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF			99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY			99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY			99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY			99.40
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0008

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part I
Date/Time Prepared:
1/28/2021 3:56 pm

			Title XVIII		Hospital	PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	1,590,411	0	1,590,411	22,069	72.07	30.00
31.00	INTENSIVE CARE UNIT	577,361		577,361	3,649	158.22	31.00
40.00	SUBPROVIDER - IPF	190,704	0	190,704	2,981	63.97	40.00
41.00	SUBPROVIDER - IRF	386,200	0	386,200	5,157	74.89	41.00
43.00	NURSERY	0		0	0	0.00	43.00
44.00	SKILLED NURSING FACILITY	425,112		425,112	7,095	59.92	44.00
200.00	Total (lines 30 through 199)	3,169,788		3,169,788	40,951		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	8,964	646,035				
31.00	INTENSIVE CARE UNIT	1,296	205,053				
40.00	SUBPROVIDER - IPF	2,789	178,412				
41.00	SUBPROVIDER - IRF	2,688	201,304				
43.00	NURSERY	0	0				
44.00	SKILLED NURSING FACILITY	4,931	295,466				
200.00	Total (lines 30 through 199)	20,668	1,526,270				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0008

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part II
Date/Time Prepared:
1/28/2021 3:56 pm

			Title XVIII		Hospital	PPS		
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,721,942	26,341,591	0.065370	3,529,100	230,697	50.00
51.00	05100	RECOVERY ROOM	67,337	11,179,607	0.006023	1,664,033	10,022	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	159,941	16,223,983	0.009858	2,516,762	24,810	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	486,464	19,700,844	0.024693	2,027,702	50,070	54.00
56.00	05600	RADIOISOTOPE	51,018	3,588,819	0.014216	636,383	9,047	56.00
56.01	03630	ULTRASOUND	90,079	10,298,061	0.008747	1,061,216	9,282	56.01
57.00	05700	CT SCAN	123,410	40,998,143	0.003010	4,571,411	13,760	57.00
58.00	05800	MRI	218,499	10,756,667	0.020313	833,147	16,924	58.00
59.00	05900	CARDIAC CATHETERIZATION	392,429	15,778,880	0.024871	4,075,326	101,357	59.00
60.00	06000	LABORATORY	427,061	62,612,733	0.006821	11,172,754	76,209	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	71,189	11,067,297	0.006432	3,654,119	23,503	65.00
66.00	06600	PHYSICAL THERAPY	231,341	17,992,302	0.012858	1,551,121	19,944	66.00
67.00	06700	OCCUPATIONAL THERAPY	53,104	2,853,554	0.018610	364,629	6,786	67.00
68.00	06800	SPEECH PATHOLOGY	179,636	1,125,130	0.159658	89,093	14,224	68.00
69.00	06900	ELECTROCARDIOLOGY	29,656	15,667,417	0.001893	3,315,903	6,277	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	36,210	1,969,898	0.018382	114,524	2,105	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	238,981	7,335,600	0.032578	1,637,206	53,337	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	214,571	10,042,043	0.021367	2,865,059	61,218	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	326,256	23,720,101	0.013754	5,345,932	73,528	73.00
73.01	07301	OUTPATIENT PHARMACY	0	0	0.000000	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
76.00	03950	LITHOTRIPSY	0	0	0.000000	0	0	76.00
76.01	03951	CARDIAC REHABILITATION	111,494	1,431,960	0.077861	148	12	76.01
76.02	03020	GASTROINTESTINAL SERVICES	162,946	26,949,120	0.006046	1,390,632	8,408	76.02
76.03	03030	ANGIOCARDIOGRAPHY	0	0	0.000000	0	0	76.03
76.05	03954	INPATIENT RENAL DIALYSIS	0	0	0.000000	0	0	76.05
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	21,953	16,197	1.355374	92	125	90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES	0	0	0.000000	0	0	90.01
90.02	04950	WOUND CARE	72,012	4,528,397	0.015902	7,248	115	90.02
90.03	09003	RIVER FOREST	0	0	0.000000	0	0	90.03
91.00	09100	EMERGENCY	663,232	67,489,283	0.009827	6,790,983	66,735	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	197,818	16,686,842	0.011855	3,211,966	38,078	92.00
200.00		Total (lines 50 through 199)	6,348,579	426,354,469		62,426,489	916,573	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0008		Period: From 07/01/2019 To 06/30/2020		Worksheet D Part III Date/Time Prepared: 1/28/2021 3:56 pm		
					Title XVIII		Hospital		PPS		
Cost Center Description			Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost				
			1A	1.00	2A	2.00	3.00				
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	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		
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		
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	22,069	0.00	8,964		30.00		
31.00	03100	INTENSIVE CARE UNIT	0	0	3,649	0.00	1,296		31.00		
40.00	04000	SUBPROVIDER - IPF	0	0	2,981	0.00	2,789		40.00		
41.00	04100	SUBPROVIDER - IRF	0	0	5,157	0.00	2,688		41.00		
43.00	04300	NURSERY	0	0	0	0.00	0		43.00		
44.00	04400	SKILLED NURSING FACILITY	0	0	7,095	0.00	4,931		44.00		
200.00		Total (lines 30 through 199)	0	0	40,951		20,668		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
43.00	04300	NURSERY	0								43.00
44.00	04400	SKILLED NURSING FACILITY	0								44.00
200.00		Total (lines 30 through 199)	0								200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0008		Period: From 07/01/2019 To 06/30/2020		Worksheet D Part IV Date/Time Prepared: 1/28/2021 3:56 pm	
				Title XVIII		Hospital		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM		0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE		0	0	0	0	0	56.00
56.01	03630	ULTRASOUND		0	0	0	0	0	56.01
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
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS		0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY		0	0	0	0	0	65.00
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	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	0	73.00
73.01	07301	OUTPATIENT PHARMACY		0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS		0	0	0	0	0	74.00
76.00	03950	LITHOTRIPSY		0	0	0	0	0	76.00
76.01	03951	CARDIAC REHABILITATION		0	0	0	0	0	76.01
76.02	03020	GASTROINTESTINAL SERVICES		0	0	0	0	0	76.02
76.03	03030	ANGIOCARDIOGRAPHY		0	0	0	0	0	76.03
76.05	03954	INPATIENT RENAL DIALYSIS		0	0	0	0	0	76.05
76.97	07697	CARDIAC REHABILITATION		0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY		0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES		0	0	0	0	0	90.01
90.02	04950	WOUND CARE		0	0	0	0	0	90.02
90.03	09003	RIVER FOREST		0	0	0	0	0	90.03
91.00	09100	EMERGENCY		0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0008

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part IV
Date/Time Prepared:
1/28/2021 3:56 pm

			Title XVIII		Hospital	PPS		
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	26,341,591	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	11,179,607	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	16,223,983	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	19,700,844	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	3,588,819	0.000000	56.00
56.01	03630	ULTRASOUND	0	0	0	10,298,061	0.000000	56.01
57.00	05700	CT SCAN	0	0	0	40,998,143	0.000000	57.00
58.00	05800	MRI	0	0	0	10,756,667	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	15,778,880	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	62,612,733	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	11,067,297	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	17,992,302	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,853,554	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,125,130	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	15,667,417	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	1,969,898	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	7,335,600	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	10,042,043	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	23,720,101	0.000000	73.00
73.01	07301	OUTPATIENT PHARMACY	0	0	0	0	0.000000	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0.000000	74.00
76.00	03950	LITHOTRIPSY	0	0	0	0	0.000000	76.00
76.01	03951	CARDIAC REHABILITATION	0	0	0	1,431,960	0.000000	76.01
76.02	03020	GASTROINTESTINAL SERVICES	0	0	0	26,949,120	0.000000	76.02
76.03	03030	ANGIOCARDIOGRAPHY	0	0	0	0	0.000000	76.03
76.05	03954	INPATIENT RENAL DIALYSIS	0	0	0	0	0.000000	76.05
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	16,197	0.000000	90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES	0	0	0	0	0.000000	90.01
90.02	04950	WOUND CARE	0	0	0	4,528,397	0.000000	90.02
90.03	09003	RIVER FOREST	0	0	0	0	0.000000	90.03
91.00	09100	EMERGENCY	0	0	0	67,489,283	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	16,686,842	0.000000	92.00
200.00	Total (lines 50 through 199)		0	0	0	426,354,469		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0008

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part IV
Date/Time Prepared:
1/28/2021 3:56 pm

			Title XVIII			Hospital	PPS	
Cost Center Description			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0.000000	3,529,100	0	4,778,159	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	1,664,033	0	1,521,941	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	2,516,762	0	2,414,027	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	2,027,702	0	2,315,053	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	636,383	0	955,002	0	56.00
56.01	03630	ULTRASOUND	0.000000	1,061,216	0	1,685,089	0	56.01
57.00	05700	CT SCAN	0.000000	4,571,411	0	7,409,125	0	57.00
58.00	05800	MRI	0.000000	833,147	0	2,407,479	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	4,075,326	0	2,844,209	0	59.00
60.00	06000	LABORATORY	0.000000	11,172,754	0	4,577,400	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.000000	3,654,119	0	255,219	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	1,551,121	0	16,839	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	364,629	0	7,907	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	89,093	0	99,610	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	3,315,903	0	2,538,082	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	114,524	0	394,617	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	1,637,206	0	848,273	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	2,865,059	0	669,878	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	5,345,932	0	2,099,527	0	73.00
73.01	07301	OUTPATIENT PHARMACY	0.000000	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00	03950	LITHOTRIPSY	0.000000	0	0	0	0	76.00
76.01	03951	CARDIAC REHABILITATION	0.000000	148	0	605,308	0	76.01
76.02	03020	GASTROINTESTINAL SERVICES	0.000000	1,390,632	0	5,787,857	0	76.02
76.03	03030	ANGIOCARDIOGRAPHY	0.000000	0	0	0	0	76.03
76.05	03954	INPATIENT RENAL DIALYSIS	0.000000	0	0	0	0	76.05
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	92	0	5,661	0	90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES	0.000000	0	0	0	0	90.01
90.02	04950	WOUND CARE	0.000000	7,248	0	2,065,209	0	90.02
90.03	09003	RIVER FOREST	0.000000	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.000000	6,790,983	0	7,132,622	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	3,211,966	0	2,058,140	0	92.00
200.00	Total (lines 50 through 199)			62,426,489	0	55,492,233	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0008

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part V
Date/Time Prepared:
1/28/2021 3:56 pm

			Title XVIII		Hospital		PPS		
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs			
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
			1.00	2.00	3.00	4.00	5.00		
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.421679	4,778,159	0	0	2,014,849	50.00	
51.00	05100	RECOVERY ROOM	0.073978	1,521,941	0	0	112,590	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00	
53.00	05300	ANESTHESIOLOGY	0.031009	2,414,027	0	0	74,857	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.196758	2,315,053	0	0	455,505	54.00	
56.00	05600	RADIOISOTOPE	0.164378	955,002	0	0	156,981	56.00	
56.01	03630	ULTRASOUND	0.091452	1,685,089	0	0	154,105	56.01	
57.00	05700	CT SCAN	0.028272	7,409,125	0	0	209,471	57.00	
58.00	05800	MRI	0.067485	2,407,479	0	0	162,469	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0.126413	2,844,209	0	0	359,545	59.00	
60.00	06000	LABORATORY	0.106691	4,577,400	0	0	488,367	60.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30	
65.00	06500	RESPIRATORY THERAPY	0.209279	255,219	0	0	53,412	65.00	
66.00	06600	PHYSICAL THERAPY	0.208292	16,839	0	0	3,507	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0.206734	7,907	0	0	1,635	67.00	
68.00	06800	SPEECH PATHOLOGY	0.815246	99,610	0	0	81,207	68.00	
69.00	06900	ELECTROCARDIOLOGY	0.049083	2,538,082	0	0	124,577	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0.132435	394,617	0	0	52,261	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.986760	848,273	0	0	837,042	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.710432	669,878	0	0	475,903	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.232019	2,099,527	0	10,658	487,130	73.00	
73.01	07301	OUTPATIENT PHARMACY	0.000000	0	0	0	0	73.01	
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00	
76.00	03950	LITHOTRIPSY	0.000000	0	0	0	0	76.00	
76.01	03951	CARDIAC REHABILITATION	0.415391	605,308	0	0	251,439	76.01	
76.02	03020	GASTROINTESTINAL SERVICES	0.077267	5,787,857	0	0	447,210	76.02	
76.03	03030	ANGIOCARDIOGRAPHY	0.000000	0	0	0	0	76.03	
76.05	03954	INPATIENT RENAL DIALYSIS	0.000000	0	0	0	0	76.05	
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98	
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99	
	OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	7.861085	5,661	0	0	44,502	90.00	
90.01	09001	OUTPATIENT INFUSION PROCEDURES	0.000000	0	0	0	0	90.01	
90.02	04950	WOUND CARE	0.261850	2,065,209	0	0	540,775	90.02	
90.03	09003	RIVER FOREST	0.000000	0	0	0	0	90.03	
91.00	09100	EMERGENCY	0.112301	7,132,622	0	0	801,001	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.146072	2,058,140	0	0	300,637	92.00	
200.00		Subtotal (see instructions)		55,492,233	0	10,658	8,690,977	200.00	
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00	
202.00		Net Charges (line 200 - line 201)		55,492,233	0	10,658	8,690,977	202.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0008

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part V
Date/Time Prepared:
1/28/2021 3:56 pm

			Title XVIII		Hospital	PPS
Cost Center Description			Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
56.01	03630	ULTRASOUND	0	0		56.01
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
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,473		73.00
73.01	07301	OUTPATIENT PHARMACY	0	0		73.01
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	LITHOTRIPSY	0	0		76.00
76.01	03951	CARDIAC REHABILITATION	0	0		76.01
76.02	03020	GASTROINTESTINAL SERVICES	0	0		76.02
76.03	03030	ANGIOCARDIOGRAPHY	0	0		76.03
76.05	03954	INPATIENT RENAL DIALYSIS	0	0		76.05
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0		76.99
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	0		90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES	0	0		90.01
90.02	04950	WOUND CARE	0	0		90.02
90.03	09003	RIVER FOREST	0	0		90.03
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	2,473		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	2,473		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0008

Period:

Worksheet D

Component CCN: 14-S008

From 07/01/2019
To 06/30/2020Part II
Date/Time Prepared:
1/28/2021 3:56 pm

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	1,721,942	26,341,591	0.065370	0	0	50.00
51.00	05100 RECOVERY ROOM	67,337	11,179,607	0.006023	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300 ANESTHESIOLOGY	159,941	16,223,983	0.009858	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	486,464	19,700,844	0.024693	17,623	435	54.00
56.00	05600 RADIOISOTOPE	51,018	3,588,819	0.014216	0	0	56.00
56.01	03630 ULTRASOUND	90,079	10,298,061	0.008747	9,117	80	56.01
57.00	05700 CT SCAN	123,410	40,998,143	0.003010	82,145	247	57.00
58.00	05800 MRI	218,499	10,756,667	0.020313	72,267	1,468	58.00
59.00	05900 CARDIAC CATHETERIZATION	392,429	15,778,880	0.024871	8,362	208	59.00
60.00	06000 LABORATORY	427,061	62,612,733	0.006821	583,851	3,982	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	71,189	11,067,297	0.006432	48,774	314	65.00
66.00	06600 PHYSICAL THERAPY	231,341	17,992,302	0.012858	128,416	1,651	66.00
67.00	06700 OCCUPATIONAL THERAPY	53,104	2,853,554	0.018610	27,451	511	67.00
68.00	06800 SPEECH PATHOLOGY	179,636	1,125,130	0.159658	15,916	2,541	68.00
69.00	06900 ELECTROCARDIOLOGY	29,656	15,667,417	0.001893	35,602	67	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	36,210	1,969,898	0.018382	11,822	217	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	238,981	7,335,600	0.032578	1,566	51	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	214,571	10,042,043	0.021367	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	326,256	23,720,101	0.013754	112,906	1,553	73.00
73.01	07301 OUTPATIENT PHARMACY	0	0	0.000000	0	0	73.01
74.00	07400 RENAL DIALYSIS	0	0	0.000000	0	0	74.00
76.00	03950 LITHOTRIPSY	0	0	0.000000	0	0	76.00
76.01	03951 CARDIAC REHABILITATION	111,494	1,431,960	0.077861	0	0	76.01
76.02	03020 GASTROINTESTINAL SERVICES	162,946	26,949,120	0.006046	0	0	76.02
76.03	03030 ANGIOCARDIOGRAPHY	0	0	0.000000	0	0	76.03
76.05	03954 INPATIENT RENAL DIALYSIS	0	0	0.000000	0	0	76.05
76.97	07697 CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699 LITHOTRIPSY	0	0	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	21,953	16,197	1.355374	0	0	90.00
90.01	09001 OUTPATIENT INFUSION PROCEDURES	0	0	0.000000	0	0	90.01
90.02	04950 WOUND CARE	72,012	4,528,397	0.015902	0	0	90.02
90.03	09003 RIVER FOREST	0	0	0.000000	0	0	90.03
91.00	09100 EMERGENCY	663,232	67,489,283	0.009827	125,121	1,230	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	16,686,842	0.000000	0	0	92.00
200.00	Total (lines 50 through 199)	6,150,761	426,354,469		1,280,939	14,555	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0008 Component CCN: 14-S008		Period: From 07/01/2019 To 06/30/2020		Worksheet D Part IV Date/Time Prepared: 1/28/2021 3:56 pm	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM		0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE		0	0	0	0	0	56.00
56.01	03630	ULTRASOUND		0	0	0	0	0	56.01
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
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS		0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY		0	0	0	0	0	65.00
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	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	0	73.00
73.01	07301	OUTPATIENT PHARMACY		0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS		0	0	0	0	0	74.00
76.00	03950	LITHOTRIPSY		0	0	0	0	0	76.00
76.01	03951	CARDIAC REHABILITATION		0	0	0	0	0	76.01
76.02	03020	GASTROINTESTINAL SERVICES		0	0	0	0	0	76.02
76.03	03030	ANGIOCARDIOGRAPHY		0	0	0	0	0	76.03
76.05	03954	INPATIENT RENAL DIALYSIS		0	0	0	0	0	76.05
76.97	07697	CARDIAC REHABILITATION		0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY		0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES		0	0	0	0	0	90.01
90.02	04950	WOUND CARE		0	0	0	0	0	90.02
90.03	09003	RIVER FOREST		0	0	0	0	0	90.03
91.00	09100	EMERGENCY		0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0008 Component CCN: 14-S008		Period: From 07/01/2019 To 06/30/2020		Worksheet D Part IV Date/Time Prepared: 1/28/2021 3:56 pm	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description				All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
				4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	26,341,591	0.000000	50.00
51.00	05100	RECOVERY ROOM		0	0	0	11,179,607	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	16,223,983	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	19,700,844	0.000000	54.00
56.00	05600	RADIOISOTOPE		0	0	0	3,588,819	0.000000	56.00
56.01	03630	ULTRASOUND		0	0	0	10,298,061	0.000000	56.01
57.00	05700	CT SCAN		0	0	0	40,998,143	0.000000	57.00
58.00	05800	MRI		0	0	0	10,756,667	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	15,778,880	0.000000	59.00
60.00	06000	LABORATORY		0	0	0	62,612,733	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS		0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY		0	0	0	11,067,297	0.000000	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	17,992,302	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	2,853,554	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	1,125,130	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	15,667,417	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	1,969,898	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	7,335,600	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	10,042,043	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	23,720,101	0.000000	73.00
73.01	07301	OUTPATIENT PHARMACY		0	0	0	0	0.000000	73.01
74.00	07400	RENAL DIALYSIS		0	0	0	0	0.000000	74.00
76.00	03950	LITHOTRIPSY		0	0	0	0	0.000000	76.00
76.01	03951	CARDIAC REHABILITATION		0	0	0	1,431,960	0.000000	76.01
76.02	03020	GASTROINTESTINAL SERVICES		0	0	0	26,949,120	0.000000	76.02
76.03	03030	ANGIOCARDIOGRAPHY		0	0	0	0	0.000000	76.03
76.05	03954	INPATIENT RENAL DIALYSIS		0	0	0	0	0.000000	76.05
76.97	07697	CARDIAC REHABILITATION		0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY		0	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	16,197	0.000000	90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES		0	0	0	0	0.000000	90.01
90.02	04950	WOUND CARE		0	0	0	4,528,397	0.000000	90.02
90.03	09003	RIVER FOREST		0	0	0	0	0.000000	90.03
91.00	09100	EMERGENCY		0	0	0	67,489,283	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	16,686,842	0.000000	92.00
200.00		Total (lines 50 through 199)		0	0	0	426,354,469		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0008 Component CCN: 14-S008		Period: From 07/01/2019 To 06/30/2020		Worksheet D Part IV Date/Time Prepared: 1/28/2021 3:56 pm	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	17,623	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	0	56.00
56.01	03630	ULTRASOUND	0.000000	9,117	0	0	0	0	56.01
57.00	05700	CT SCAN	0.000000	82,145	0	0	0	0	57.00
58.00	05800	MRI	0.000000	72,267	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	8,362	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	583,851	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.000000	48,774	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	128,416	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	27,451	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	15,916	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	35,602	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	11,822	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	1,566	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	112,906	0	0	0	0	73.00
73.01	07301	OUTPATIENT PHARMACY	0.000000	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	0	74.00
76.00	03950	LITHOTRIPSY	0.000000	0	0	0	0	0	76.00
76.01	03951	CARDIAC REHABILITATION	0.000000	0	0	0	0	0	76.01
76.02	03020	GASTROINTESTINAL SERVICES	0.000000	0	0	0	0	0	76.02
76.03	03030	ANGIOCARDIOGRAPHY	0.000000	0	0	0	0	0	76.03
76.05	03954	INPATIENT RENAL DIALYSIS	0.000000	0	0	0	0	0	76.05
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0.000000	0	0	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES	0.000000	0	0	0	0	0	90.01
90.02	04950	WOUND CARE	0.000000	0	0	0	0	0	90.02
90.03	09003	RIVER FOREST	0.000000	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.000000	125,121	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)			1,280,939	0	0	0	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0008

Period:

Worksheet D

Component CCN: 14-T008

From 07/01/2019
To 06/30/2020Part II
Date/Time Prepared:
1/28/2021 3:56 pm

				Title XVIII	Subprovider - IRF	PPS		
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,721,942	26,341,591	0.065370	15,901	1,039	50.00
51.00	05100	RECOVERY ROOM	67,337	11,179,607	0.006023	10,791	65	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	159,941	16,223,983	0.009858	5,437	54	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	486,464	19,700,844	0.024693	30,882	763	54.00
56.00	05600	RADIOISOTOPE	51,018	3,588,819	0.014216	2,017	29	56.00
56.01	03630	ULTRASOUND	90,079	10,298,061	0.008747	32,009	280	56.01
57.00	05700	CT SCAN	123,410	40,998,143	0.003010	63,242	190	57.00
58.00	05800	MRI	218,499	10,756,667	0.020313	10,629	216	58.00
59.00	05900	CARDIAC CATHETERIZATION	392,429	15,778,880	0.024871	38,155	949	59.00
60.00	06000	LABORATORY	427,061	62,612,733	0.006821	466,784	3,184	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	71,189	11,067,297	0.006432	304,427	1,958	65.00
66.00	06600	PHYSICAL THERAPY	231,341	17,992,302	0.012858	2,029,465	26,095	66.00
67.00	06700	OCCUPATIONAL THERAPY	53,104	2,853,554	0.018610	283,950	5,284	67.00
68.00	06800	SPEECH PATHOLOGY	179,636	1,125,130	0.159658	176,100	28,116	68.00
69.00	06900	ELECTROCARDIOLOGY	29,656	15,667,417	0.001893	32,533	62	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	36,210	1,969,898	0.018382	3,534	65	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	238,981	7,335,600	0.032578	46,364	1,510	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	214,571	10,042,043	0.021367	538	11	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	326,256	23,720,101	0.013754	408,183	5,614	73.00
73.01	07301	OUTPATIENT PHARMACY	0	0	0.000000	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
76.00	03950	LITHOTRIPSY	0	0	0.000000	0	0	76.00
76.01	03951	CARDIAC REHABILITATION	111,494	1,431,960	0.077861	9	1	76.01
76.02	03020	GASTROINTESTINAL SERVICES	162,946	26,949,120	0.006046	4,793	29	76.02
76.03	03030	ANGIOCARDIOGRAPHY	0	0	0.000000	0	0	76.03
76.05	03954	INPATIENT RENAL DIALYSIS	0	0	0.000000	0	0	76.05
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	21,953	16,197	1.355374	1	1	90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES	0	0	0.000000	0	0	90.01
90.02	04950	WOUND CARE	72,012	4,528,397	0.015902	0	0	90.02
90.03	09003	RIVER FOREST	0	0	0.000000	0	0	90.03
91.00	09100	EMERGENCY	663,232	67,489,283	0.009827	15,159	149	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	16,686,842	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	6,150,761	426,354,469		3,980,903	75,664	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0008 Component CCN: 14-T008		Period: From 07/01/2019 To 06/30/2020		Worksheet D Part IV Date/Time Prepared: 1/28/2021 3:56 pm	
				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	0	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE		0	0	0	0	0	56.00
56.01	03630	ULTRASOUND		0	0	0	0	0	56.01
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
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS		0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY		0	0	0	0	0	65.00
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	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	0	73.00
73.01	07301	OUTPATIENT PHARMACY		0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS		0	0	0	0	0	74.00
76.00	03950	LITHOTRIPSY		0	0	0	0	0	76.00
76.01	03951	CARDIAC REHABILITATION		0	0	0	0	0	76.01
76.02	03020	GASTROINTESTINAL SERVICES		0	0	0	0	0	76.02
76.03	03030	ANGIOCARDIOGRAPHY		0	0	0	0	0	76.03
76.05	03954	INPATIENT RENAL DIALYSIS		0	0	0	0	0	76.05
76.97	07697	CARDIAC REHABILITATION		0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY		0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES		0	0	0	0	0	90.01
90.02	04950	WOUND CARE		0	0	0	0	0	90.02
90.03	09003	RIVER FOREST		0	0	0	0	0	90.03
91.00	09100	EMERGENCY		0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0008 Component CCN: 14-T008		Period: From 07/01/2019 To 06/30/2020		Worksheet D Part IV Date/Time Prepared: 1/28/2021 3:56 pm	
				Title XVIII		Subprovider - IRF		PPS	
Cost Center Description				All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
				4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	26,341,591	0.000000	50.00
51.00	05100	RECOVERY ROOM		0	0	0	11,179,607	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	16,223,983	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	19,700,844	0.000000	54.00
56.00	05600	RADIOISOTOPE		0	0	0	3,588,819	0.000000	56.00
56.01	03630	ULTRASOUND		0	0	0	10,298,061	0.000000	56.01
57.00	05700	CT SCAN		0	0	0	40,998,143	0.000000	57.00
58.00	05800	MRI		0	0	0	10,756,667	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	15,778,880	0.000000	59.00
60.00	06000	LABORATORY		0	0	0	62,612,733	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS		0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY		0	0	0	11,067,297	0.000000	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	17,992,302	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY		0	0	0	2,853,554	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	1,125,130	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	15,667,417	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	1,969,898	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	7,335,600	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	10,042,043	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	23,720,101	0.000000	73.00
73.01	07301	OUTPATIENT PHARMACY		0	0	0	0	0.000000	73.01
74.00	07400	RENAL DIALYSIS		0	0	0	0	0.000000	74.00
76.00	03950	LITHOTRIPSY		0	0	0	0	0.000000	76.00
76.01	03951	CARDIAC REHABILITATION		0	0	0	1,431,960	0.000000	76.01
76.02	03020	GASTROINTESTINAL SERVICES		0	0	0	26,949,120	0.000000	76.02
76.03	03030	ANGIOCARDIOGRAPHY		0	0	0	0	0.000000	76.03
76.05	03954	INPATIENT RENAL DIALYSIS		0	0	0	0	0.000000	76.05
76.97	07697	CARDIAC REHABILITATION		0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY		0	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	16,197	0.000000	90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES		0	0	0	0	0.000000	90.01
90.02	04950	WOUND CARE		0	0	0	4,528,397	0.000000	90.02
90.03	09003	RIVER FOREST		0	0	0	0	0.000000	90.03
91.00	09100	EMERGENCY		0	0	0	67,489,283	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	16,686,842	0.000000	92.00
200.00		Total (lines 50 through 199)		0	0	0	426,354,469		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0008 Component CCN: 14-T008		Period: From 07/01/2019 To 06/30/2020		Worksheet D Part IV Date/Time Prepared: 1/28/2021 3:56 pm	
				Title XVIII		Subprovider - IRF		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0.000000		15,901	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000		10,791	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000		5,437	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		30,882	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.000000		2,017	0	0	0	56.00
56.01	03630	ULTRASOUND	0.000000		32,009	0	0	0	56.01
57.00	05700	CT SCAN	0.000000		63,242	0	0	0	57.00
58.00	05800	MRI	0.000000		10,629	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		38,155	0	0	0	59.00
60.00	06000	LABORATORY	0.000000		466,784	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000		0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.000000		304,427	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000		2,029,465	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		283,950	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		176,100	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		32,533	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		3,534	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		46,364	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		538	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		408,183	0	0	0	73.00
73.01	07301	OUTPATIENT PHARMACY	0.000000		0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0.000000		0	0	0	0	74.00
76.00	03950	LITHOTRIPSY	0.000000		0	0	0	0	76.00
76.01	03951	CARDIAC REHABILITATION	0.000000		9	0	0	0	76.01
76.02	03020	GASTROINTESTINAL SERVICES	0.000000		4,793	0	0	0	76.02
76.03	03030	ANGIOCARDIOGRAPHY	0.000000		0	0	0	0	76.03
76.05	03954	INPATIENT RENAL DIALYSIS	0.000000		0	0	0	0	76.05
76.97	07697	CARDIAC REHABILITATION	0.000000		0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000		0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000		0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0.000000		1	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES	0.000000		0	0	0	0	90.01
90.02	04950	WOUND CARE	0.000000		0	0	0	0	90.02
90.03	09003	RIVER FOREST	0.000000		0	0	0	0	90.03
91.00	09100	EMERGENCY	0.000000		15,159	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		0	0	0	0	92.00
200.00		Total (lines 50 through 199)			3,980,903	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0008	Period: From 07/01/2019 To 06/30/2020	Worksheet D-1 Date/Time Prepared: 1/28/2021 3:56 pm
		Title XVIII	Hospital	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		22,069	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		22,069	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)		19,324	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		8,964	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)		19,596,651	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)		19,596,651	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)		19,596,651	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)		887.97	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		7,959,763	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		7,959,763	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0008

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

Worksheet D-1

Date/Time Prepared:
1/28/2021 3:56 pm

		Title XVIII		Hospital	PPS	
Cost Center Description		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0
	Intensive Care Type Inpatient Hospital Units					
43.00	INTENSIVE CARE UNIT	6,857,604	3,649	1,879.31	1,296	2,435,586
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)					11,829,601
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					22,224,950
	PASS THROUGH COST ADJUSTMENTS					
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					851,088
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					916,573
52.00	Total Program excludable cost (sum of lines 50 and 51)					1,767,661
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					20,457,289
	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)					2,745
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					887.97
89.00	Observation bed cost (line 87 x line 88) (see instructions)					2,437,478

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0008

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

Worksheet D-1

Date/Time Prepared:
1/28/2021 3:56 pm

			Title XVIII		Hospital	PPS	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,590,411	19,596,651	0.081157	2,437,478	197,818	90.00
91.00	Nursing School cost	0	19,596,651	0.000000	2,437,478	0	91.00
92.00	Allied health cost	0	19,596,651	0.000000	2,437,478	0	92.00
93.00	All other Medical Education	0	19,596,651	0.000000	2,437,478	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0008 Component CCN: 14-S008	Period: From 07/01/2019 To 06/30/2020	Worksheet D-1 Date/Time Prepared: 1/28/2021 3:56 pm
		Title XVIII	Subprovider - IPF	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,981	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,981	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)		2,981	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		2,789	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		2,396,721	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,396,721	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		2,396,721	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)		804.00	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,242,356	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)		2,242,356	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0008	Period: From 07/01/2019 To 06/30/2020	Worksheet D-1
			Component CCN: 14-S008		Date/Time Prepared: 1/28/2021 3:56 pm
			Title XVIII	Subprovider - IPF	PPS
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0
Intensive Care Type Inpatient Hospital Units					
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0
44.00 CORONARY CARE UNIT					
45.00 BURN INTENSIVE CARE UNIT					
46.00 SURGICAL INTENSIVE CARE UNIT					
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)					175,559
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,417,915
PASS THROUGH COST ADJUSTMENTS					
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					178,412
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					14,555
52.00 Total Program excludable cost (sum of lines 50 and 51)					192,967
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					2,224,948
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: 14-0008 Component CCN: 14-S008		Period: From 07/01/2019 To 06/30/2020	Worksheet D-1 Date/Time Prepared: 1/28/2021 3:56 pm	
		Title XVIII		Subprovider - IPF	PPS	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	190,704	2,396,721	0.079569	0	0 90.00
91.00	Nursing School cost	0	2,396,721	0.000000	0	0 91.00
92.00	Allied health cost	0	2,396,721	0.000000	0	0 92.00
93.00	All other Medical Education	0	2,396,721	0.000000	0	0 93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0008	Period: From 07/01/2019 To 06/30/2020	Worksheet D-1
		Component CCN: 14-T008		Date/Time Prepared: 1/28/2021 3:56 pm
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		5,157	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		5,157	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)		5,157	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		2,688	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)		4,399,801	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)		4,399,801	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)		4,399,801	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)		853.17	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,293,321	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)		2,293,321	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0008	Period: From 07/01/2019 To 06/30/2020	Worksheet D-1
			Component CCN: 14-T008		Date/Time Prepared: 1/28/2021 3:56 pm
			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)					907,822
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					3,201,143
PASS THROUGH COST ADJUSTMENTS					
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					201,304
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					75,664
52.00 Total Program excludable cost (sum of lines 50 and 51)					276,968
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					2,924,175
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: 14-0008 Component CCN: 14-T008		Period: From 07/01/2019 To 06/30/2020		Worksheet D-1 Date/Time Prepared: 1/28/2021 3:56 pm	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	386,200	4,399,801	0.087777	0	0	90.00
91.00	Nursing School cost	0	4,399,801	0.000000	0	0	91.00
92.00	Allied health cost	0	4,399,801	0.000000	0	0	92.00
93.00	All other Medical Education	0	4,399,801	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0008 Component CCN: 14-5526	Period: From 07/01/2019 To 06/30/2020	Worksheet D-1 Date/Time Prepared: 1/28/2021 3:56 pm
		Title XVIII	Skilled Nursing Facility	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		7,095	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		7,095	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)		7,095	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		4,931	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)		5,640,642	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)		5,640,642	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)		5,640,642	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0008	Period: From 07/01/2019 To 06/30/2020	Worksheet D-1	
				Component CCN: 14-5526		Date/Time Prepared: 1/28/2021 3:56 pm	
				Title XVIII		Skilled Nursing Facility	PPS
Cost Center Description		Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)	
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)			
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)						52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges						54.00
55.00	Target amount per discharge						55.00
56.00	Target amount (line 54 x line 55)						56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57.00
58.00	Bonus payment (see instructions)						58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						61.00
62.00	Relief payment (see instructions)						62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)						63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						5,640,642 70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						795.02 71.00
72.00	Program routine service cost (line 9 x line 71)						3,920,244 72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						0 73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						3,920,244 74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						0 75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						0.00 76.00
77.00	Program capital-related costs (line 9 x line 76)						0 77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						0 78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						0 79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						0 80.00
81.00	Inpatient routine service cost per diem limitation						0.00 81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						0 82.00
83.00	Reasonable inpatient routine service costs (see instructions)						3,920,244 83.00
84.00	Program inpatient ancillary services (see instructions)						1,228,961 84.00
85.00	Utilization review - physician compensation (see instructions)						0 85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						5,149,205 86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)						0 87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						0.00 88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)						0 89.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0008 Component CCN: 14-5526		Period: From 07/01/2019 To 06/30/2020	Worksheet D-1 Date/Time Prepared: 1/28/2021 3:56 pm	
			Title XVIII		Skilled Nursing Facility	PPS	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0008	Period: From 07/01/2019 To 06/30/2020	Worksheet D-3 Date/Time Prepared: 1/28/2021 3:56 pm	
			Title XVIII	Hospital	PPS	
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		35,974,343		30.00
31.00	03100	INTENSIVE CARE UNIT		7,353,689		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY				43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.421679	3,529,100	1,488,147	50.00
51.00	05100	RECOVERY ROOM	0.073978	1,664,033	123,102	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.031009	2,516,762	78,042	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.196758	2,027,702	398,967	54.00
56.00	05600	RADIOISOTOPE	0.164378	636,383	104,607	56.00
56.01	03630	ULTRASOUND	0.091452	1,061,216	97,050	56.01
57.00	05700	CT SCAN	0.028272	4,571,411	129,243	57.00
58.00	05800	MRI	0.067485	833,147	56,225	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.126413	4,075,326	515,174	59.00
60.00	06000	LABORATORY	0.106691	11,172,754	1,192,032	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.209279	3,654,119	764,730	65.00
66.00	06600	PHYSICAL THERAPY	0.208292	1,551,121	323,086	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.206734	364,629	75,381	67.00
68.00	06800	SPEECH PATHOLOGY	0.815246	89,093	72,633	68.00
69.00	06900	ELECTROCARDIOLOGY	0.049083	3,315,903	162,754	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.132435	114,524	15,167	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.986760	1,637,206	1,615,529	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.710432	2,865,059	2,035,430	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.232019	5,345,932	1,240,358	73.00
73.01	07301	OUTPATIENT PHARMACY	0.000000	0	0	73.01
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
76.00	03950	LITHOTRIPSY	0.000000	0	0	76.00
76.01	03951	CARDIAC REHABILITATION	0.415391	148	61	76.01
76.02	03020	GASTROINTESTINAL SERVICES	0.077267	1,390,632	107,450	76.02
76.03	03030	ANGIOCARDIOGRAPHY	0.000000	0	0	76.03
76.05	03954	INPATIENT RENAL DIALYSIS	0.000000	0	0	76.05
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	7.861085	92	723	90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES	0.000000	0	0	90.01
90.02	04950	WOUND CARE	0.261850	7,248	1,898	90.02
90.03	09003	RIVER FOREST	0.000000	0	0	90.03
91.00	09100	EMERGENCY	0.112301	6,790,983	762,634	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.146072	3,211,966	469,178	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		62,426,489	11,829,601	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00		Net charges (line 200 minus line 201)		62,426,489		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0008 Component CCN: 14-S008	Period: From 07/01/2019 To 06/30/2020	Worksheet D-3 Date/Time Prepared: 1/28/2021 3:56 pm	
		Title XVIII	Subprovider - IPF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
40.00	04000 SUBPROVIDER - IPF		9,209,465		40.00
41.00	04100 SUBPROVIDER - IRF		0		41.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.421679	0	0	50.00
51.00	05100 RECOVERY ROOM	0.073978	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.031009	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.196758	17,623	3,467	54.00
56.00	05600 RADIOISOTOPE	0.164378	0	0	56.00
56.01	03630 ULTRASOUND	0.091452	9,117	834	56.01
57.00	05700 CT SCAN	0.028272	82,145	2,322	57.00
58.00	05800 MRI	0.067485	72,267	4,877	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.126413	8,362	1,057	59.00
60.00	06000 LABORATORY	0.106691	583,851	62,292	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0.209279	48,774	10,207	65.00
66.00	06600 PHYSICAL THERAPY	0.208292	128,416	26,748	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.206734	27,451	5,675	67.00
68.00	06800 SPEECH PATHOLOGY	0.815246	15,916	12,975	68.00
69.00	06900 ELECTROCARDIOLOGY	0.049083	35,602	1,747	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.132435	11,822	1,566	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.986760	1,566	1,545	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.710432	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.232019	112,906	26,196	73.00
73.01	07301 OUTPATIENT PHARMACY	0.000000	0	0	73.01
74.00	07400 RENAL DIALYSIS	0.000000	0	0	74.00
76.00	03950 LITHOTRIPSY	0.000000	0	0	76.00
76.01	03951 CARDIAC REHABILITATION	0.415391	0	0	76.01
76.02	03020 GASTROINTESTINAL SERVICES	0.077267	0	0	76.02
76.03	03030 ANGIOCARDIOGRAPHY	0.000000	0	0	76.03
76.05	03954 INPATIENT RENAL DIALYSIS	0.000000	0	0	76.05
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699 LITHOTRIPSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	7.861085	0	0	90.00
90.01	09001 OUTPATIENT INFUSION PROCEDURES	0.000000	0	0	90.01
90.02	04950 WOUND CARE	0.261850	0	0	90.02
90.03	09003 RIVER FOREST	0.000000	0	0	90.03
91.00	09100 EMERGENCY	0.112301	125,121	14,051	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.146072	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		1,280,939	175,559	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		1,280,939	0	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0008 Component CCN: 14-T008	Period: From 07/01/2019 To 06/30/2020	Worksheet D-3 Date/Time Prepared: 1/28/2021 3:56 pm	
		Title XVIII	Subprovider - IRF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		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		7,049,629		41.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.421679	15,901	6,705	50.00
51.00	05100 RECOVERY ROOM	0.073978	10,791	798	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.031009	5,437	169	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.196758	30,882	6,076	54.00
56.00	05600 RADIOISOTOPE	0.164378	2,017	332	56.00
56.01	03630 ULTRASOUND	0.091452	32,009	2,927	56.01
57.00	05700 CT SCAN	0.028272	63,242	1,788	57.00
58.00	05800 MRI	0.067485	10,629	717	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.126413	38,155	4,823	59.00
60.00	06000 LABORATORY	0.106691	466,784	49,802	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0.209279	304,427	63,710	65.00
66.00	06600 PHYSICAL THERAPY	0.208292	2,029,465	422,721	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.206734	283,950	58,702	67.00
68.00	06800 SPEECH PATHOLOGY	0.815246	176,100	143,565	68.00
69.00	06900 ELECTROCARDIOLOGY	0.049083	32,533	1,597	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.132435	3,534	468	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.986760	46,364	45,750	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.710432	538	382	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.232019	408,183	94,706	73.00
73.01	07301 OUTPATIENT PHARMACY	0.000000	0	0	73.01
74.00	07400 RENAL DIALYSIS	0.000000	0	0	74.00
76.00	03950 LITHOTRIPSY	0.000000	0	0	76.00
76.01	03951 CARDIAC REHABILITATION	0.415391	9	4	76.01
76.02	03020 GASTROINTESTINAL SERVICES	0.077267	4,793	370	76.02
76.03	03030 ANGIOCARDIOGRAPHY	0.000000	0	0	76.03
76.05	03954 INPATIENT RENAL DIALYSIS	0.000000	0	0	76.05
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699 LITHOTRIPSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	7.861085	1	8	90.00
90.01	09001 OUTPATIENT INFUSION PROCEDURES	0.000000	0	0	90.01
90.02	04950 WOUND CARE	0.261850	0	0	90.02
90.03	09003 RIVER FOREST	0.000000	0	0	90.03
91.00	09100 EMERGENCY	0.112301	15,159	1,702	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.146072	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		3,980,903	907,822	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net charges (line 200 minus line 201)		3,980,903	0	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0008	Period: From 07/01/2019 To 06/30/2020	Worksheet D-3	
		Component CCN: 14-5526		Date/Time Prepared: 1/28/2021 3:56 pm	
		Title XVIII	Skilled Nursing Facility	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		0		41.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.421679	29	12	50.00
51.00	05100 RECOVERY ROOM	0.073978	1,496	111	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.031009	25,731	798	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.196758	56,680	11,152	54.00
56.00	05600 RADIOISOTOPE	0.164378	13,715	2,254	56.00
56.01	03630 ULTRASOUND	0.091452	46,892	4,288	56.01
57.00	05700 CT SCAN	0.028272	733	21	57.00
58.00	05800 MRI	0.067485	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.126413	20,979	2,652	59.00
60.00	06000 LABORATORY	0.106691	599,420	63,953	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0.209279	612,660	128,217	65.00
66.00	06600 PHYSICAL THERAPY	0.208292	2,627,921	547,375	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.206734	414,039	85,596	67.00
68.00	06800 SPEECH PATHOLOGY	0.815246	109,251	89,066	68.00
69.00	06900 ELECTROCARDIOLOGY	0.049083	39,936	1,960	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.132435	6,756	895	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.986760	140,396	138,537	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.710432	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.232019	641,279	148,789	73.00
73.01	07301 OUTPATIENT PHARMACY	0.000000	0	0	73.01
74.00	07400 RENAL DIALYSIS	0.000000	0	0	74.00
76.00	03950 LITHOTRIPSY	0.000000	0	0	76.00
76.01	03951 CARDIAC REHABILITATION	0.415391	24	10	76.01
76.02	03020 GASTROINTESTINAL SERVICES	0.077267	31,641	2,445	76.02
76.03	03030 ANGIOCARDIOGRAPHY	0.000000	0	0	76.03
76.05	03954 INPATIENT RENAL DIALYSIS	0.000000	0	0	76.05
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699 LITHOTRIPSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	7.861085	0	0	90.00
90.01	09001 OUTPATIENT INFUSION PROCEDURES	0.000000	0	0	90.01
90.02	04950 WOUND CARE	0.261850	527	138	90.02
90.03	09003 RIVER FOREST	0.000000	0	0	90.03
91.00	09100 EMERGENCY	0.112301	2,713	305	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.146072	2,647	387	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		5,395,465	1,228,961	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)		5,395,465		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0008

Period:
From 07/01/2019
To 06/30/2020Worksheet E
Part A
Date/Time Prepared:
1/28/2021 3:56 pm

		Title XVIII	Hospital	PPS	
				1.00	
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS					
1.00	DRG Amounts Other than Outlier Payments			0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)			19,798,655	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)			0	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)			177,371	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)			0	2.04
3.00	Managed Care Simulated Payments			9,220,333	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)			127.50	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)			3.30	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.			0.57	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).			0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.			0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)			0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)			2.73	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records			3.89	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)			2.73	12.00
13.00	Total allowable FTE count for the prior year.			2.87	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.			2.78	14.00
15.00	Sum of lines 12 through 14 divided by 3.			2.79	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			2.79	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).			0.021882	19.00
20.00	Prior year resident to bed ratio (see instructions)			0.024933	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)			0.021882	21.00
22.00	IME payment adjustment (see instructions)			235,347	22.00
22.01	IME payment adjustment - Managed Care (see instructions)			109,602	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)			1.16	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)			235,347	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			109,602	29.01
Disproportionate Share Adjustment					
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)			3.79	30.00
31.00	Percentage of Medicaid patient days (see instructions)			14.66	31.00
32.00	Sum of lines 30 and 31			18.45	32.00
33.00	Allowable disproportionate share percentage (see instructions)			4.74	33.00
34.00	Disproportionate share adjustment (see instructions)			234,614	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0008	Period: From 07/01/2019 To 06/30/2020	Worksheet E Part A Date/Time Prepared: 1/28/2021 3:56 pm	
		Title XVIII	Hospital	PPS	
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)		0	0	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000		35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	1,485,897	1,371,883		35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	374,528	1,027,038		35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,401,566			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)	21,847,553			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)			21,957,155	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			1,638,468	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).			65,752	52.00
53.00	Nursing and Allied Health Managed Care payment			0	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)			0	58.00
59.00	Total (sum of amounts on lines 49 through 58)			23,661,375	59.00
60.00	Primary payer payments			0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			23,661,375	61.00
62.00	Deductibles billed to program beneficiaries			2,087,316	62.00
63.00	Coinsurance billed to program beneficiaries			124,465	63.00
64.00	Allowable bad debts (see instructions)			473,896	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			308,032	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			405,028	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			21,757,626	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)			88,132	70.93
70.94	HRR adjustment amount (see instructions)			-82,692	70.94
70.95	Recovery of accelerated depreciation			0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0008	Period: From 07/01/2019 To 06/30/2020	Worksheet E Part A Date/Time Prepared: 1/28/2021 3:56 pm
		Title XVIII	Hospital	PPS
		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		21,763,066	71.00
71.01	Sequestration adjustment (see instructions)		363,443	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs		0	71.03
72.00	Interim payments		21,121,154	72.00
72.01	Interim payments-PARHM		0	72.01
73.00	Tentative settlement (for contractor use only)		0	73.00
73.01	Tentative settlement-PARHM (for contractor use only)		0	73.01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		278,469	74.00
74.01	Balance due provider/program-PARHM (see instructions)		0	74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		1,211,907	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: 14-0008

Period:
From 07/01/2019
To 06/30/2020Worksheet E
Part A Exhibit 4
Date/Time Prepared:
1/28/2021 3:56 pm

				Title XVIII		Hospital	PPS
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)
		0	1.00	2.00	3.00	4.00	5.00
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	19,798,655	0	19,798,655		19,798,655
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	0	0		0	0
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0
2.00	Outlier payments for discharges (see instructions)	2.00					
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	177,371	0	177,371		177,371
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	0	0		0	0
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0
4.00	Managed care simulated payments	3.00	9,220,333	0	9,220,333	0	9,220,333
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.021882	0.021882	0.021882	0.021882	
6.00	IME payment adjustment (see instructions)	22.00	235,347	0	235,347	0	235,347
6.01	IME payment adjustment for managed care (see instructions)	22.01	109,602	0	109,602	0	109,602
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000	
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0
9.00	Total IME payment (sum of lines 6 and 8)	29.00	235,347	0	235,347	0	235,347
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	109,602	0	109,602	0	109,602
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0474	0.0474	0.0474	0.0474	
11.00	Disproportionate share adjustment (see instructions)	34.00	234,614	0	234,614	0	234,614
11.01	Uncompensated care payments	36.00	1,401,566	0	374,528	1,027,038	1,401,566
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	21,847,553	0	20,820,515	1,027,038	21,847,553
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	21,957,155	0	20,930,117	1,027,038	21,957,155
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,638,468	0	1,638,468	0	1,638,468

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0008

Period:
From 07/01/2019
To 06/30/2020Worksheet E
Part A Exhibit 4
Date/Time Prepared:
1/28/2021 3:56 pm

		Title XVIII		Hospital		PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)
		0	1.00	2.00	3.00	4.00	5.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0
17.01	Net organ aquisition cost						
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0
19.00	SUBTOTAL			0	22,568,585	1,027,038	23,595,623
		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	1,576,292	0	1,576,292	0	1,576,292
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0
21.00	Capital DRG outlier payments	2.00	42,315	0	42,315	0	42,315
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0
22.00	Indirect medical education percentage (see instructions)	5.00	0.0126	0.0126	0.0126	0.0126	
23.00	Indirect medical education adjustment (see instructions)	6.00	19,861	0	19,861	0	19,861
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000	0.0000	
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	0
26.00	Total prospective capital payments (see instructions)	12.00	1,638,468	0	1,638,468	0	1,638,468
		W/S E, Part A line	(Amounts to E, Part A)				
		0	1.00	2.00	3.00	4.00	5.00
27.00	Low volume adjustment factor				0.000000	0.000000	
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y				

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0008

Period:
From 07/01/2019
To 06/30/2020Worksheet E
Part A Exhibit 5
Date/Time Prepared:
1/28/2021 3:56 pm

		Title XVIII		Hospital		PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	19,798,655	19,798,655		19,798,655	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	0		0	0	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	177,371	177,371		177,371	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	0		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	9,220,333	9,220,333	0	9,220,333	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.021882	0.021882	0.021882		5.00
6.00	IME payment adjustment (see instructions)	22.00	235,347	235,347	0	235,347	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	109,602	109,602	0	109,602	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	235,347	235,347	0	235,347	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	109,602	109,602	0	109,602	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0474	0.0474	0.0474		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	234,614	234,614	0	234,614	11.00
11.01	Uncompensated care payments	36.00	1,401,566	374,528	1,027,038	1,401,566	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	21,847,553	20,820,515	1,027,038	21,847,553	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	21,957,155	20,930,117	1,027,038	21,957,155	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,638,468	1,638,468	0	1,638,468	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			22,568,585	1,027,038	23,595,623	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0008

Period:
From 07/01/2019
To 06/30/2020Worksheet E
Part A Exhibit 5
Date/Time Prepared:
1/28/2021 3:56 pm

		Title XVIII		Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	1,576,292	1,576,292	0	1,576,292	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	42,315	42,315	0	42,315	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	0.0126	0.0126	0.0126		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	19,861	19,861	0	19,861	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,638,468	1,638,468	0	1,638,468	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	88,132	88,132	0	88,132	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	-82,692	-82,692	0	-82,692	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: 14-0008	Period: From 07/01/2019 To 06/30/2020	Worksheet E Part B Date/Time Prepared: 1/28/2021 3:56 pm
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		2,473	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		8,690,977	2.00
3.00	OPPS payments		9,186,062	3.00
4.00	Outlier payment (see instructions)		1,894	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		2,473	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		10,658	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)		10,658	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)		10,658	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		8,185	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)		2,473	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)		9,187,956	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		1,815,532	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)		7,374,897	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		16,485	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)		7,391,382	30.00
31.00	Primary payer payments		397	31.00
32.00	Subtotal (line 30 minus line 31)		7,390,985	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)		286,605	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		186,293	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		200,765	36.00
37.00	Subtotal (see instructions)		7,577,278	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		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)		7,577,278	40.00
40.01	Sequestration adjustment (see instructions)		126,541	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		0	40.03
41.00	Interim payments		7,466,560	41.00
41.01	Interim payments-PARHM		0	41.01
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		0	42.01
43.00	Balance due provider/program (see instructions)		-15,823	43.00
43.01	Balance due provider/program-PARHM (see instructions)		0	43.01
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0008

Period:
From 07/01/2019
To 06/30/2020Worksheet E-1
Part I
Date/Time Prepared:
1/28/2021 3:56 pm

		Title XVIII		Hospital		PPS
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		21,015,742		7,437,954	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	03/23/2020	105,412	03/23/2020	28,606	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)		105,412		28,606	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)		21,121,154		7,466,560	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		278,469		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		15,823	6.02
7.00	Total Medicare program liability (see instructions)		21,399,623		7,450,737	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: 14-0008 Component CCN: 14-S008		Period: From 07/01/2019 To 06/30/2020		Worksheet E-1 Part I Date/Time Prepared: 1/28/2021 3:56 pm	
		Title XVIII		Subprovider - IPF		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider					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		2,685,556			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)		2,685,556			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		29,818			0	6.01
6.02	SETTLEMENT TO PROGRAM		0			0	6.02
7.00	Total Medicare program liability (see instructions)		2,715,374			0	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: 14-0008
 Component CCN: 14-T008

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

 Worksheet E-1
 Part I
 Date/Time Prepared:
 1/28/2021 3:56 pm

		Title XVIII		Subprovider - IRF		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider					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		4,269,372			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)		4,269,372			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		44,715			0	6.01
6.02	SETTLEMENT TO PROGRAM		0			0	6.02
7.00	Total Medicare program liability (see instructions)		4,314,087			0	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: 14-0008
 Component CCN: 14-5526

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

 Worksheet E-1
 Part I
 Date/Time Prepared:
 1/28/2021 3:56 pm

		Title XVIII		Skilled Nursing Facility		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		2,669,639			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)		2,669,639			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		7,035			0	6.01
6.02	SETTLEMENT TO PROGRAM		0			0	6.02
7.00	Total Medicare program liability (see instructions)		2,676,674			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: 14-0008	Period: From 07/01/2019 To 06/30/2020	Worksheet E-1 Part II Date/Time Prepared: 1/28/2021 3:56 pm
		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0008 Component CCN: 14-S008	Period: From 07/01/2019 To 06/30/2020	Worksheet E-3 Part II Date/Time Prepared: 1/28/2021 3:56 pm
		Title XVIII	Subprovider - IPF	PPS
				1.00
	PART II - MEDICARE PART A SERVICES - IPF PPS			
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)			2,887,732 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 instnctions)			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 instnctions)			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)			8.144809 9.00
10.00	Teaching Adjustment Factor {{{1 + (line 8/line 9)) 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)			2,887,732 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)			2,887,732 16.00
17.00	Primary payer payments			0 17.00
18.00	Subtotal (line 16 less line 17).			2,887,732 18.00
19.00	Deductibles			138,336 19.00
20.00	Subtotal (line 18 minus line 19)			2,749,396 20.00
21.00	Coinsurance			19,547 21.00
22.00	Subtotal (line 20 minus line 21)			2,729,849 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			48,680 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			31,642 24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			29,824 25.00
26.00	Subtotal (sum of lines 22 and 24)			2,761,491 26.00
27.00	Direct graduate medical education payments (see instructions)			0 27.00
28.00	Other pass through costs (see instructions)			0 28.00
29.00	Outlier payments reconciliation			0 29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 30.50
30.99	Demonstration payment adjustment amount before sequestration			0 30.99
31.00	Total amount payable to the provider (see instructions)			2,761,491 31.00
31.01	Sequestration adjustment (see instructions)			46,117 31.01
31.02	Demonstration payment adjustment amount after sequestration			0 31.02
32.00	Interim payments			2,685,556 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)			29,818 34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 35.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2			0 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0008 Component CCN: 14-T008	Period: From 07/01/2019 To 06/30/2020	Worksheet E-3 Part III Date/Time Prepared: 1/28/2021 3:56 pm
		Title XVIII	Subprovider - IRF	PPS
				1.00
	PART III - MEDICARE PART A SERVICES - IRF PPS			
1.00	Net Federal PPS Payment (see instructions)		4,224,091	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)		0.0220	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)		189,662	3.00
4.00	Outlier Payments		12,898	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)		14.090164	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)		4,426,651	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)		4,426,651	17.00
18.00	Primary payer payments		0	18.00
19.00	Subtotal (line 17 less line 18).		4,426,651	19.00
20.00	Deductibles		17,996	20.00
21.00	Subtotal (line 19 minus line 20)		4,408,655	21.00
22.00	Coinsurance		38,522	22.00
23.00	Subtotal (line 21 minus line 22)		4,370,133	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		26,497	24.00
25.00	Adjusted reimbursable bad debts (see instructions)		17,223	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		23,817	26.00
27.00	Subtotal (sum of lines 23 and 25)		4,387,356	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)		0	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)		4,387,356	32.00
32.01	Sequestration adjustment (see instructions)		73,269	32.01
32.02	Demonstration payment adjustment amount after sequestration		0	32.02
33.00	Interim payments		4,269,372	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)		44,715	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		12,898	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: 14-0008 Component CCN: 14-5526	Period: From 07/01/2019 To 06/30/2020	Worksheet E-3 Part VI Date/Time Prepared: 1/28/2021 3:56 pm
		Title XVIII	Skilled Nursing Facility	PPS
				1.00
PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES				
PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)				
1.00	Resource Utilization Group Payment (RUGS)			2,908,668 1.00
2.00	Routine service other pass through costs			0 2.00
3.00	Ancillary service other pass through costs			0 3.00
4.00	Subtotal (sum of lines 1 through 3)			2,908,668 4.00
COMPUTATION OF NET COST OF COVERED SERVICES				
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)			5.00
6.00	Deductible			0 6.00
7.00	Coinsurance			188,788 7.00
8.00	Allowable bad debts (see instructions)			3,409 8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			496 9.00
10.00	Adjusted reimbursable bad debts (see instructions)			2,216 10.00
11.00	Utilization review			0 11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)			2,722,096 12.00
13.00	Inpatient primary payer payments			0 13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 14.50
14.99	Demonstration payment adjustment amount before sequestration			0 14.99
15.00	Subtotal (see instructions)			2,722,096 15.00
15.01	Sequestration adjustment (see instructions)			45,422 15.01
15.02	Demonstration payment adjustment amount after sequestration			0 15.02
15.75	Sequestration for non-claims based amounts (see instructions)			37 15.75
16.00	Interim payments			2,669,639 16.00
17.00	Tentative settlement (for contractor use only)			0 17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 15.02, 15.75, 16, and 17)			6,998 18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2			0 19.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0008		Period: From 07/01/2019 To 06/30/2020	Worksheet E-4 Date/Time Prepared: 1/28/2021 3:56 pm	
		Title XVIII		Hospital		PPS
						1.00
COMPUTATION OF TOTAL DIRECT GME AMOUNT						
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.					1.54 1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)					0.00 2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA					0.00 3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)					0.23 3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))					0.00 4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)					0.00 4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)					0.00 4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts)					1.31 5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)					3.89 6.00
7.00	Enter the lesser of line 5 or line 6					1.31 7.00
		Primary Care	Other	Total		
		1.00	2.00	3.00		
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	0.00	3.89	3.89		8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	0.00	1.31	1.31		9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00			10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		0.00			10.01
11.00	Total weighted FTE count	0.00	1.31			11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	1.19			12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	1.16			13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	0.00	1.22			14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00			15.00
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00			15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00			16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00			16.01
17.00	Adjusted rolling average FTE count	0.00	1.22			17.00
18.00	Per resident amount	99,765.58	99,765.58			18.00
19.00	Approved amount for resident costs	0	121,714	121,714		19.00
				1.00		
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00		20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			2.58		21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00		22.00
23.00	Enter the locality adjustment national average per resident amount (see instructions)			0.00		23.00
24.00	Multiply line 22 time line 23			0		24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			121,714		25.00
		Inpatient Part A	Managed Care Prior to 1/1	Managed Care On or after 1/1	Total	
		1.00	2.00	2.01	3.00	
COMPUTATION OF PROGRAM PATIENT LOAD						
26.00	Inpatient Days (see instructions)	15,737	2,840	2,841	26.00	
27.00	Total Inpatient Days (see instructions)	31,111	31,111	31,111	27.00	
28.00	Ratio of inpatient days to total inpatient days	0.505834	0.091286	0.091318	28.00	
29.00	Program direct GME amount	61,567	11,111	11,115	83,793	29.00
29.01	Percent reduction for MA DGME		7.00	7.00		29.01
30.00	Reduction for direct GME payments for Medicare Advantage		778	778	1,556	30.00
31.00	Net Program direct GME amount				82,237	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0008	Period: From 07/01/2019 To 06/30/2020	Worksheet E-4 Date/Time Prepared: 1/28/2021 3:56 pm	
		Title XVIII	Hospital	PPS	
				1.00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)			0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)			0	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)			0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)			0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)			0	36.00
APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY					
Part A Reasonable Cost					
37.00	Reasonable cost (see instructions)			34,672,920	37.00
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)			0	38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)			0	39.00
40.00	Primary payer payments (see instructions)			0	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)			34,672,920	41.00
Part B Reasonable Cost					
42.00	Reasonable cost (see instructions)			8,693,450	42.00
43.00	Primary payer payments (see instructions)			397	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)			8,693,053	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)			43,365,973	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)			0.799542	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)			0.200458	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B					
48.00	Total program GME payment (line 31)			82,237	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)			65,752	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)			16,485	50.00

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

Provider CCN: 14-0008

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

Worksheet G

Date/Time Prepared:
1/28/2021 3:56 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	5,678,090	0	0	0	1.00
2.00	Temporary investments	93,275,255	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	26,417,669	0	0	0	4.00
5.00	Other receivable	111,764,346	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-12,587,140	0	0	0	6.00
7.00	Inventory	3,019,002	0	0	0	7.00
8.00	Prepaid expenses	220,983	0	0	0	8.00
9.00	Other current assets	7,237,244	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	235,025,449	0	0	0	11.00
FIXED ASSETS						
12.00	Land	12,500,000	0	0	0	12.00
13.00	Land improvements	1,249,191	0	0	0	13.00
14.00	Accumulated depreciation	-579,149	0	0	0	14.00
15.00	Buildings	84,475,974	0	0	0	15.00
16.00	Accumulated depreciation	-36,574,126	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	49,442,161	0	0	0	23.00
24.00	Accumulated depreciation	-40,453,913	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)	70,060,138	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	5,293,449	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	5,293,449	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	310,379,036	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	177,879,139	0	0	0	37.00
38.00	Salaries, wages, and fees payable	3,808,050	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	10,866,117	0	0	0	43.00
44.00	Other current liabilities	537,812	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	193,091,118	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	20,110,672	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	20,110,672	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	213,201,790	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	97,177,246				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)	97,177,246	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	310,379,036	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0008

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

Worksheet G-1

Date/Time Prepared:
1/28/2021 3:56 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		92,169,823		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		5,007,423				2.00
3.00	Total (sum of line 1 and line 2)		97,177,246		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		97,177,246		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)		97,177,246		0		19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-0008

Period:
From 07/01/2019
To 06/30/2020Worksheet G-2
Parts I & II
Date/Time Prepared:
1/28/2021 3:56 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	83,864,121		83,864,121	1.00
2.00	SUBPROVIDER - IPF	9,858,167		9,858,167	2.00
3.00	SUBPROVIDER - IRF	12,219,489		12,219,489	3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	16,078,479		16,078,479	7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	122,020,256		122,020,256	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	20,928,811		20,928,811	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)	20,928,811		20,928,811	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	142,949,067		142,949,067	17.00
18.00	Ancillary services	158,947,938		158,947,938	18.00
19.00	Outpatient services	0	256,303,507	256,303,507	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
24.20	OUTPATIENT PHYSICAL THERAPY	0	0	0	24.20
24.30	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	24.30
24.40	OUTPATIENT SPEECH PATHOLOGY	0	0	0	24.40
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	Other (specify)	0	0	0	27.00
27.02	OTHER PATIENT REVENUES	0	1,620,817	1,620,817	27.02
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	301,897,005	257,924,324	559,821,329	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		121,967,105		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)		121,967,105		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0008

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

Worksheet G-3

Date/Time Prepared:
1/28/2021 3:56 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	559,821,329	1.00
2.00	Less contractual allowances and discounts on patients' accounts	444,610,780	2.00
3.00	Net patient revenues (line 1 minus line 2)	115,210,549	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	121,967,105	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-6,756,556	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	1,052,099	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	2,678	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	2,163,491	22.00
23.00	Governmental appropriations	0	23.00
24.00	DAY CARE	0	24.00
24.02	DESCRIPTION REQUIRED	1,725,636	24.02
24.04	OTHER INCOME	3,617,835	24.04
24.50	COVID-19 PHE Funding	3,202,240	24.50
25.00	Total other income (sum of lines 6-24)	11,763,979	25.00
26.00	Total (line 5 plus line 25)	5,007,423	26.00
27.00	Other expenses specify	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	5,007,423	29.00

CALCULATION OF CAPITAL PAYMENT

Provider CCN: 14-0008

Period:
From 07/01/2019
To 06/30/2020Worksheet L
Parts I-III
Date/Time Prepared:
1/28/2021 3:56 pm

Title XVIII		Hospital	PPS
			1.00
PART I - FULLY PROSPECTIVE METHOD			
CAPITAL FEDERAL AMOUNT			
1.00	Capital DRG other than outlier	1,576,292	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	42,315	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)	63.07	3.00
4.00	Number of interns & residents (see instructions)	2.79	4.00
5.00	Indirect medical education percentage (see instructions)	1.26	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)	19,861	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (see instructions)	0	11.00
12.00	Total prospective capital payments (see instructions)	1,638,468	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