

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: 14-0095	Period: From 07/01/2019 To 06/30/2020	Worksheet S Parts I-III Date/Time Prepared: 1/28/2021 12:08 pm
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 1/28/2021	Time: 12:08 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 SAINT ANTHONY HOSPITAL (14-0095) 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) BOB ENKEMA

Officer or Administrator of Provider(s)

EXECUTIVE VP & CFO

Title

01/28/2021 12:08:10 PM

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	743,279	20,937	0	0	1.00
2.00	Subprovider - IPF	0	316	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	0	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
200.00	Total	0	743,595	20,937	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0095		Period: From 07/01/2019 To 06/30/2020		Worksheet S-2 Part I Date/Time Prepared: 1/28/2021 12:08 pm	
1.00		2.00		3.00		4.00			
Hospital and Hospital Health Care Complex Address:									
1.00	Street: 2875 W. 19TH STREET			PO Box:				1.00	
2.00	City: CHICAGO			State: IL		Zip Code: 60623		County: COOK	
		Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)	
								V	XVIII
								XIX	
Hospital and Hospital-Based Component Identification:									
3.00	Hospital			SAINT ANTHONY HOSPITAL	140095	16974	1	07/01/1966	N
4.00	Subprovider - IPF			SAINT ANTHONY HOSPITAL	14S095	16974	4	07/01/1984	N
5.00	Subprovider - IRF								P
6.00	Subprovider - (Other)								P
7.00	Swing Beds - SNF								O
8.00	Swing Beds - NF								O
9.00	Hospital-Based SNF								
10.00	Hospital-Based NF								
11.00	Hospital-Based OLTC								
12.00	Hospital-Based HHA								
13.00	Separately Certified ASC								
14.00	Hospital-Based Hospice								
15.00	Hospital-Based Health Clinic - RHC								
16.00	Hospital-Based Health Clinic - FQHC								
17.00	Hospital-Based (CMHC) I								
17.20	Hospital-Based (OPT) I								
17.30	Hospital-Based (OOT) I								
17.40	Hospital-Based (OSP) I								
18.00	Renal Dialysis								
19.00	Other								
							From:	To:	
							1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)						07/01/2019	06/30/2020	
21.00	Type of Control (see instructions)						2		
							1.00	2.00	
							2.00	3.00	
Inpatient PPS Information									
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N		
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y	Y		
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N	N	
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		

Worksheet S-2
Part I
Date/Time Prepared:
1/28/2021 12:08 pm

MCRIF32 - 16.6.170.2

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0095		Period: From 07/01/2019 To 06/30/2020		Worksheet S-2 Part I Date/Time Prepared: 1/28/2021 12:08 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	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
		Program Name		Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00		2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.20
						1.00	
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)							
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)					0.00	62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	63.00
		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))			
		1.00	2.00	3.00			
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00		0.00	0.000000	64.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0095

Period:
From 07/01/2019
To 06/30/2020Worksheet S-2
Part I
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1/28/2021 12:08 pm

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

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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	Y	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.06
Rural Providers				
105.00	Does this hospital qualify as a CAH?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)			107.00
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
		1.00	2.00	3.00
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.			4.00
				1.00
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.			N

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		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00
		1.00	2.00	3.00
112.00	Did this hospital participate in the Pennsylvania Rural Health Model demonstration for any portion of the current cost reporting period? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable.	N		112.00
Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N		116.00
117.00	Is this facility legally required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1		118.00
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	685,915	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.	Y		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)	N		140.00

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1.00		2.00		3.00					
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.									
141.00	Name:	Contractor's Name:		Contractor's Number:				141.00	
142.00	Street:	PO Box:						142.00	
143.00	City:	State:		Zip Code:				143.00	
								1.00	
144.00	Are provider based physicians' costs included in Worksheet A?							Y	144.00
								1.00	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	145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.								146.00
								1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.							N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.							N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.							N	149.00
				Part A	Part B	Title V	Title XIX		
				1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)									
155.00	Hospital	N	N	N	N	N	155.00		
156.00	Subprovider - IPF	N	N	N	N	N	156.00		
157.00	Subprovider - IRF	N	N	N	N	N	157.00		
158.00	SUBPROVIDER						158.00		
159.00	SNF	N	N	N	N	N	159.00		
160.00	HOME HEALTH AGENCY	N	N	N	N	N	160.00		
161.00	CMHC		N	N	N	N	161.00		
161.20	OUTPATIENT PHYSICAL THERAPY		N	N	N	N	161.20		
161.30	OUTPATIENT OCCUPATIONAL THERAPY		N	N	N	N	161.30		
161.40	OUTPATIENT SPEECH PATHOLOGY		N	N	N	N	161.40		
								1.00	
Multicampus									
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.							N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus		
		0	1.00	2.00	3.00	4.00	5.00		
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00		
								1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act									
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.							Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)								168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)								168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)							9.99	169.00
						Beginning	Ending		
						1.00	2.00		
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)								170.00
						1.00	2.00		
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)							N	0

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0095		Period: From 07/01/2019 To 06/30/2020		Worksheet S-2 Part II Date/Time Prepared: 1/28/2021 12:08 pm	
				Y/N	Date		
				1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.							
COMPLETED BY ALL HOSPITALS							
Provider Organization and Operation							
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)			N			1.00
				Y/N	Date	V/I	
				1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.			N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)			N			3.00
				Y/N	Type	Date	
				1.00	2.00	3.00	
Financial Data and Reports							
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.			Y	A	12/31/2019	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.			N			5.00
				Y/N	Legal Oper.		
				1.00	2.00		
Approved Educational Activities							
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?			N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.			N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.			N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.			Y			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.			N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.			N			11.00
				Y/N			
				1.00			
Bad Debts							
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.					Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.					N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.					N	14.00
Bed Complement							
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.					N	15.00
				Part A		Part B	
				Y/N	Date	Y/N	Date
				1.00	2.00	3.00	4.00
PS&R Data							
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)			N		N	
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)			Y	10/30/2019	Y	10/30/2019
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: 14-0095

Period:
From 07/01/2019
To 06/30/2020Worksheet S-2
Part II
Date/Time Prepared:
1/28/2021 12:08 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0095

Period:
From 07/01/2019
To 06/30/2020Worksheet S-2
Part II
Date/Time Prepared:
1/28/2021 12:08 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0095

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part I
Date/Time Prepared:
1/28/2021 12:08 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	94	34,404	0.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		94	34,404	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	15	5,490	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		109	39,894	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	42	15,372		0	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
25.20 CMHC - OUTPATIENT PHYSICAL THERAPY	99.20				0	25.20
25.30 CMHC - OUTPATIENT OCCUPATIONAL THERAPY	99.30				0	25.30
25.40 CMHC - OUTPATIENT SPEECH PATHOLOGY	99.40				0	25.40
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		151				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00
33.01 LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0095

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part I
Date/Time Prepared:
1/28/2021 12:08 pm

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	1,584	1,432	14,475			1.00
2.00	HMO and other (see instructions)	0	7,990				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	1,584	1,432	14,475			7.00
8.00	INTENSIVE CARE UNIT	529	489	3,501			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		2,528	2,937			13.00
14.00	Total (see instructions)	2,113	4,449	20,913	4.74	738.79	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	1,214	1,194	8,758	0.00	41.15	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			16			24.10
25.00	CMHC - CMHC						25.00
25.20	CMHC - OUTPATIENT PHYSICAL THERAPY	0	0	0	0.00	0.00	25.20
25.30	CMHC - OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0.00	0.00	25.30
25.40	CMHC - OUTPATIENT SPEECH PATHOLOGY	0	0	0	0.00	0.00	25.40
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				4.74	779.94	27.00
28.00	Observation Bed Days		64	1,802			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	320	514			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0095

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part I
Date/Time Prepared:
1/28/2021 12:08 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	439	480	4,619	1.00
2.00 HMO and other (see instructions)			0	1,998		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	439	480	4,619	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	163	0	1,307	16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
25.20 CMHC - OUTPATIENT PHYSICAL THERAPY	0.00					25.20
25.30 CMHC - OUTPATIENT OCCUPATIONAL THERAPY	0.00					25.30
25.40 CMHC - OUTPATIENT SPEECH PATHOLOGY	0.00					25.40
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0095

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part II
Date/Time Prepared:
1/28/2021 12:08 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	57,449,778	354,604	57,804,382	1,607,943.00	35.95
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		1,335,367	0	1,335,367	6,880.00	194.09
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non Physician-Part B		5,290,716	0	5,290,716	49,266.00	107.39
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		3,815,492	11,312	3,826,804	135,015.00	28.34
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		1,020,289	0	1,020,289	12,200.00	83.63
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		0	0	0	0.00	0.00
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)		10,218,538	0	10,218,538		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		973,795	0	973,795		
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		49,622	0	49,622		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		355,331	0	355,331		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related (core)		0	0	0		
25.51	Related organization wage-related (core)		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0095

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part II
Date/Time Prepared:
1/28/2021 12:08 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	973,788	5,000	978,788	20,861.00	46.92	26.00
27.00	Administrative & General	5.00	13,111,587	216,650	13,328,237	297,364.00	44.82	27.00
28.00	Administrative & General under contract (see inst.)		276,963	0	276,963	4,653.00	59.52	28.00
29.00	Maintenance & Repairs	6.00	447,695	0	447,695	12,235.00	36.59	29.00
30.00	Operation of Plant	7.00	1,265,894	0	1,265,894	53,381.00	23.71	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	832,616	0	832,616	50,068.00	16.63	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	993,183	-436,570	556,613	32,544.00	17.10	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	438,315	438,315	25,705.00	17.05	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,095,307	3,518	1,098,825	46,851.00	23.45	38.00
39.00	Central Services and Supply	14.00	317,595	3,277	320,872	13,327.00	24.08	39.00
40.00	Pharmacy	15.00	1,504,568	2,581	1,507,149	37,997.00	39.66	40.00
41.00	Medical Records & Medical Records Library	16.00	705,947	4,971	710,918	22,051.00	32.24	41.00
42.00	Social Service	17.00	776,282	0	776,282	19,621.00	39.56	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0095

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part III
Date/Time Prepared:
1/28/2021 12:08 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)	52,436,025	354,604	52,790,629	1,563,330.00	33.77	1.00
2.00	Excluded area salaries (see instructions)	3,815,492	11,312	3,826,804	135,015.00	28.34	2.00
3.00	Subtotal salaries (line 1 minus line 2)	48,620,533	343,292	48,963,825	1,428,315.00	34.28	3.00
4.00	Subtotal other wages & related costs (see inst.)	1,020,289	0	1,020,289	12,200.00	83.63	4.00
5.00	Subtotal wage-related costs (see inst.)	10,268,160	0	10,268,160	0.00	20.97	5.00
6.00	Total (sum of lines 3 thru 5)	59,908,982	343,292	60,252,274	1,440,515.00	41.83	6.00
7.00	Total overhead cost (see instructions)	22,301,425	237,742	22,539,167	636,658.00	35.40	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 14-0095	Period: From 07/01/2019 To 06/30/2020	Worksheet S-3 Part IV Date/Time Prepared: 1/28/2021 12:08 pm
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions		680,735	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution		0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)		0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)		0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration fees		0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan		0	6.00
7.00	Employee Managed Care Program Administration Fees		0	7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)		0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)		0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)		0	8.02
8.03	Health Insurance (Purchased)		4,967,225	8.03
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		180,666	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		82,116	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)		142,994	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		1,307,920	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		3,947,854	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		70,000	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		217,777	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		11,597,287	24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)			25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 14-0095

Period:
From 07/01/2019
To 06/30/2020Worksheet S-3
Part V
Date/Time Prepared:
1/28/2021 12:08 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	1,020,289	11,597,287	1.00
2.00	Hospital	1,020,289	11,597,287	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF			4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
16.20	Hospital-Based-CMHC 20	0	0	16.20
16.30	Hospital-Based-CMHC 30	0	0	16.30
16.40	Hospital-Based-CMHC 40	0	0	16.40
17.00	Renal Dialysis			17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 14-0095

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

Worksheet S-10

Date/Time Prepared:
1/28/2021 12:08 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)		0.317237	1.00
Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid		43,637,339	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid		0	5.00
6.00	Medicaid charges		164,038,127	6.00
7.00	Medicaid cost (line 1 times line 6)		52,038,963	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)		8,401,624	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)		8,401,624	19.00
			Uninsured patients	Insured patients
			1.00	2.00
			Total (col. 1 + col. 2)	3.00
Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	15,658,189	735	15,658,924
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	4,967,357	735	4,968,092
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)	4,967,357	735	4,968,092
			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)		12,677,896	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		465,885	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		716,746	27.01
28.00	Non-Medicare bad debt expense (see instructions)		11,961,150	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		4,045,380	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		9,013,472	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		17,415,096	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0095

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

Worksheet A

Date/Time Prepared:
1/28/2021 12:08 pm

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		2,481,547	2,481,547	0	2,481,547	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	0	0	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	973,788	6,485,720	7,459,508	0	7,459,508	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	13,111,587	23,976,539	37,088,126	0	37,088,126	5.00
6.00	00600	MAINTENANCE & REPAIRS	447,695	1,512,549	1,960,244	0	1,960,244	6.00
7.00	00700	OPERATION OF PLANT	1,265,894	1,602,655	2,868,549	0	2,868,549	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	832,616	1,101,206	1,933,822	0	1,933,822	9.00
10.00	01000	DIETARY	993,183	1,583,197	2,576,380	-1,137,017	1,439,363	10.00
11.00	01100	CAFETERIA	0	0	0	1,137,017	1,137,017	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	1,095,307	137,569	1,232,876	0	1,232,876	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	317,595	162,734	480,329	0	480,329	14.00
15.00	01500	PHARMACY	1,504,568	2,741,513	4,246,081	-3,051,396	1,194,685	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	705,947	472,475	1,178,422	0	1,178,422	16.00
17.00	01700	SOCIAL SERVICE	776,282	104,403	880,685	0	880,685	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	2,075,351	733,794	2,809,145	0	2,809,145	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	5,739,105	1,219,825	6,958,930	-415,639	6,543,291	30.00
31.00	03100	INTENSIVE CARE UNIT	2,067,637	462,613	2,530,250	-198,510	2,331,740	31.00
40.00	04000	SUBPROVIDER - IPF	2,460,237	949,222	3,409,459	-40,024	3,369,435	40.00
43.00	04300	NURSERY	1,394,471	268,962	1,663,433	-33,941	1,629,492	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,246,483	3,539,967	4,786,450	-1,436,229	3,350,221	50.00
51.00	05100	RECOVERY ROOM	294,320	35,438	329,758	-10,408	319,350	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,246,471	831,431	5,077,902	-291,501	4,786,401	52.00
53.00	05300	ANESTHESIOLOGY	1,592,803	564,736	2,157,539	-139,075	2,018,464	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,084,845	2,870,387	4,955,232	-506,276	4,448,956	54.00
57.00	05700	CT SCAN	426,494	449,287	875,781	-57,578	818,203	57.00
58.00	05800	MRI	132,959	93,808	226,767	-14,596	212,171	58.00
60.00	06000	LABORATORY	1,457,301	1,895,000	3,352,301	0	3,352,301	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	5,115	516,770	521,885	0	521,885	63.00
65.00	06500	RESPIRATORY THERAPY	639,085	283,914	922,999	-230,082	692,917	65.00
66.00	06600	PHYSICAL THERAPY	931,381	143,073	1,074,454	-37,265	1,037,189	66.00
69.00	06900	ELECTROCARDIOLOGY	359,287	159,057	518,344	-15,859	502,485	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	50,080	7,429	57,509	-3,447	54,062	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	3,379,237	3,379,237	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	678,854	678,854	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	3,051,396	3,051,396	73.00
75.00	07500	ASC (NON-DISTINCT PART)	410,075	51,429	461,504	-11,909	449,595	75.00
76.00	03951	HEMODIALYSIS	1,879	404,311	406,190	0	406,190	76.00
76.01	03952	DIABETES CENTER	0	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1,836,995	1,026,589	2,863,584	-49,251	2,814,333	90.00
90.01	09001	CHEMOTHERAPY	360,205	79,684	439,889	-19,523	420,366	90.01
90.02	09002	KEDZIE CLINIC	455,006	117,360	572,366	-3,999	568,367	90.02
90.03	09003	LITTLE VILLAGE CLINIC	642,274	669,753	1,312,027	-3,751	1,308,276	90.03
91.00	09100	EMERGENCY	3,160,202	3,278,475	6,438,677	-539,228	5,899,449	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	56,094,523	63,014,421	119,108,944	0	119,108,944	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	31,103	36,307	67,410	0	67,410	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	609,021	374,287	983,308	0	983,308	192.00
192.01	19201	OTHER NON-REIMBURSABLE	163,118	14,414	177,532	0	177,532	192.01
192.02	19202	NEPHROLOGY	552,013	951,549	1,503,562	0	1,503,562	192.02
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	57,449,778	64,390,978	121,840,756	0	121,840,756	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0095

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

Worksheet A

Date/Time Prepared:
1/28/2021 12:08 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	0	2,481,547	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	0	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	7,459,508	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-6,751,983	30,336,143	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	1,960,244	6.00
7.00	00700	OPERATION OF PLANT	-15,875	2,852,674	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	8.00
9.00	00900	HOUSEKEEPING	0	1,933,822	9.00
10.00	01000	DIETARY	0	1,439,363	10.00
11.00	01100	CAFETERIA	-750,195	386,822	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	-5,500	1,227,376	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	480,329	14.00
15.00	01500	PHARMACY	-319,320	875,365	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-942	1,177,480	16.00
17.00	01700	SOCIAL SERVICE	0	880,685	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	-1,779,033	1,030,112	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-459,991	6,083,300	30.00
31.00	03100	INTENSIVE CARE UNIT	-23,697	2,308,043	31.00
40.00	04000	SUBPROVIDER - IPF	-130,903	3,238,532	40.00
43.00	04300	NURSERY	-720,872	908,620	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-249,655	3,100,566	50.00
51.00	05100	RECOVERY ROOM	0	319,350	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-2,300,109	2,486,292	52.00
53.00	05300	ANESTHESIOLOGY	-1,730,694	287,770	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,448,956	54.00
57.00	05700	CT SCAN	0	818,203	57.00
58.00	05800	MRI	0	212,171	58.00
60.00	06000	LABORATORY	-17,102	3,335,199	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	521,885	63.00
65.00	06500	RESPIRATORY THERAPY	0	692,917	65.00
66.00	06600	PHYSICAL THERAPY	-2,619	1,034,570	66.00
69.00	06900	ELECTROCARDIOLOGY	0	502,485	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	54,062	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	3,379,237	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	678,854	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,051,396	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	449,595	75.00
76.00	03951	HEMODIALYSIS	0	406,190	76.00
76.01	03952	DIABETES CENTER	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	-39,090	2,775,243	90.00
90.01	09001	CHEMOTHERAPY	-48,437	371,929	90.01
90.02	09002	KEDZIE CLINIC	0	568,367	90.02
90.03	09003	LITTLE VILLAGE CLINIC	0	1,308,276	90.03
91.00	09100	EMERGENCY	-2,338,110	3,561,339	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	99.40
SPECIAL PURPOSE COST CENTERS					
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-17,684,127	101,424,817	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	67,410	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	983,308	192.00
192.01	19201	OTHER NON-REIMBURSABLE	0	177,532	192.01
192.02	19202	NEPHROLOGY	0	1,503,562	192.02
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-17,684,127	104,156,629	200.00

RECLASSIFICATIONS

Provider CCN: 14-0095

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

Worksheet A-6

Date/Time Prepared:
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	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	B - CAFETERIA RECLASS					
1.00	CAFETERIA	11.00	438,315	698,702	1.00	
	0		438,315	698,702		
	C - COST OF MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	3,379,237	1.00	
2.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	678,854	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	
	0		0	4,058,091		
	D - COST OF DRUGS SOLD					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	3,051,396	1.00	
	0		0	3,051,396		
	E - HIRING INCENTIVES					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	5,000	0	1.00	
2.00	ADMINISTRATIVE & GENERAL	5.00	216,650	0	2.00	
3.00	DIETARY	10.00	1,745	0	3.00	
4.00	NURSING ADMINISTRATION	13.00	3,518	0	4.00	
5.00	CENTRAL SERVICES & SUPPLY	14.00	3,277	0	5.00	
6.00	PHARMACY	15.00	2,581	0	6.00	
7.00	MEDICAL RECORDS & LIBRARY	16.00	4,971	0	7.00	
8.00	I&R SERVICES-OTHER PRGM	22.00	25,676	0	8.00	
	COSTS APPRV					
9.00	ADULTS & PEDIATRICS	30.00	4,812	0	9.00	
10.00	INTENSIVE CARE UNIT	31.00	4,153	0	10.00	
11.00	SUBPROVIDER - IPF	40.00	11,312	0	11.00	
12.00	NURSERY	43.00	4,768	0	12.00	
13.00	RECOVERY ROOM	51.00	3,342	0	13.00	
14.00	DELIVERY ROOM & LABOR ROOM	52.00	25,872	0	14.00	
15.00	RADIOLOGY-DIAGNOSTIC	54.00	11,425	0	15.00	
16.00	LABORATORY	60.00	1,560	0	16.00	
17.00	PHYSICAL THERAPY	66.00	3,294	0	17.00	
18.00	ASC (NON-DISTINCT PART)	75.00	4,913	0	18.00	
19.00	LITTLE VILLAGE CLINIC	90.03	2,935	0	19.00	
20.00	EMERGENCY	91.00	12,800	0	20.00	
	0		354,604	0		
500.00	Grand Total: Increases		792,919	7,808,189	500.00	

RECLASSIFICATIONS

Provider CCN: 14-0095

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

Worksheet A-6

Date/Time Prepared:
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	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	B - CAFETERIA RECLASS						
1.00	DIETARY	10.00	438,315	698,702	0		1.00
	0		438,315	698,702			
	C - COST OF MEDICAL SUPPLIES						
1.00	ADULTS & PEDIATRICS	30.00	0	415,639	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	198,510	0		2.00
3.00	SUBPROVIDER - IPF	40.00	0	40,024	0		3.00
4.00	NURSERY	43.00	0	33,941	0		4.00
5.00	OPERATING ROOM	50.00	0	1,436,229	0		5.00
6.00	RECOVERY ROOM	51.00	0	10,408	0		6.00
7.00	DELIVERY ROOM & LABOR ROOM	52.00	0	291,501	0		7.00
8.00	ANESTHESIOLOGY	53.00	0	139,075	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	506,276	0		9.00
10.00	CT SCAN	57.00	0	57,578	0		10.00
11.00	MRI	58.00	0	14,596	0		11.00
12.00	RESPIRATORY THERAPY	65.00	0	230,082	0		12.00
13.00	PHYSICAL THERAPY	66.00	0	37,265	0		13.00
14.00	ELECTROCARDIOLOGY	69.00	0	15,859	0		14.00
15.00	ELECTROENCEPHALOGRAPHY	70.00	0	3,447	0		15.00
16.00	ASC (NON-DISTINCT PART)	75.00	0	11,909	0		16.00
17.00	CLINIC	90.00	0	49,251	0		17.00
18.00	CHEMOTHERAPY	90.01	0	19,523	0		18.00
19.00	KEDZIE CLINIC	90.02	0	3,999	0		19.00
20.00	LITTLE VILLAGE CLINIC	90.03	0	3,751	0		20.00
21.00	EMERGENCY	91.00	0	539,228	0		21.00
	0		0	4,058,091			
	D - COST OF DRUGS SOLD						
1.00	PHARMACY	15.00	0	3,051,396	0		1.00
	0		0	3,051,396			
	E - HIRING INCENTIVES						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	5,000	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	216,650	0		2.00
3.00	DIETARY	10.00	0	1,745	0		3.00
4.00	NURSING ADMINISTRATION	13.00	0	3,518	0		4.00
5.00	CENTRAL SERVICES & SUPPLY	14.00	0	3,277	0		5.00
6.00	PHARMACY	15.00	0	2,581	0		6.00
7.00	MEDICAL RECORDS & LIBRARY	16.00	0	4,971	0		7.00
8.00	I&R SERVICES-OTHER PRGM	22.00	0	25,676	0		8.00
	COSTS APPRV						
9.00	ADULTS & PEDIATRICS	30.00	0	4,812	0		9.00
10.00	INTENSIVE CARE UNIT	31.00	0	4,153	0		10.00
11.00	SUBPROVIDER - IPF	40.00	0	11,312	0		11.00
12.00	NURSERY	43.00	0	4,768	0		12.00
13.00	RECOVERY ROOM	51.00	0	3,342	0		13.00
14.00	DELIVERY ROOM & LABOR ROOM	52.00	0	25,872	0		14.00
15.00	RADIOLOGY-DIAGNOSTIC	54.00	0	11,425	0		15.00
16.00	LABORATORY	60.00	0	1,560	0		16.00
17.00	PHYSICAL THERAPY	66.00	0	3,294	0		17.00
18.00	ASC (NON-DISTINCT PART)	75.00	0	4,913	0		18.00
19.00	LITTLE VILLAGE CLINIC	90.03	0	2,935	0		19.00
20.00	EMERGENCY	91.00	0	12,800	0		20.00
	0		0	354,604			
500.00	Grand Total: Decreases		438,315	8,162,793			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0095

Period:
From 07/01/2019
To 06/30/2020Worksheet A-7
Part I
Date/Time Prepared:
1/28/2021 12:08 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	991,639	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	32,836,599	603,154	0	603,154	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	41,131,085	1,025,896	0	1,025,896	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	74,959,323	1,629,050	0	1,629,050	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	74,959,323	1,629,050	0	1,629,050	0	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	991,639	0				1.00
2.00	Land Improvements	0	0				2.00
3.00	Buildings and Fixtures	33,439,753	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	42,156,981	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	76,588,373	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	76,588,373	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0095

Period:
From 07/01/2019
To 06/30/2020Worksheet A-7
Part II
Date/Time Prepared:
1/28/2021 12:08 pm

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	2,481,547	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	2,481,547	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	0	2,481,547				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	2,481,547				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0095

Period:
From 07/01/2019
To 06/30/2020Worksheet A-7
Part III
Date/Time Prepared:
1/28/2021 12:08 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	33,439,753	0	33,439,753	0.442344	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	42,156,982	0	42,156,982	0.557656	0	2.00
3.00	Total (sum of lines 1-2)	75,596,735	0	75,596,735	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	2,481,547	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	2,481,547	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	2,481,547	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	2,481,547	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0095

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

Worksheet A-8

Date/Time Prepared:
1/28/2021 12:08 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)			0ADMINISTRATIVE & GENERAL	5.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)			0	0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)			0	0.00	0	7.00
8.00	Television and radio service (chapter 21)			0	0.00	0	8.00
9.00	Parking lot (chapter 21)			0	0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-8,532,742			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)			0	0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1		0		0	12.00
13.00	Laundry and linen service			0	0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-750,195	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others			0	0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients			0	0.00	0	16.00
17.00	Sale of drugs to other than patients			0	0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-942	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)			0	0.00	0	19.00
20.00	Vending machines			0	0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)			0	0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0	0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)			0*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT			0CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP			0CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist			0NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant			0	0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)			0ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0*** Cost Center Deleted ***	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest			0	0.00	0	32.00
33.00	OTHER REVENUE	B	-181,542	ADMINISTRATIVE & GENERAL	5.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0095

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

Worksheet A-8

Date/Time Prepared:
1/28/2021 12:08 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	
36.00 OTHER REVENUE	B	-15,875	OPERATION OF PLANT	7.00	0	36.00
36.01 OTHER REVENUE	B	-5,500	NURSING ADMINISTRATION	13.00	0	36.01
36.02 OTHER REVENUE	B	-319,320	PHARMACY	15.00	0	36.02
36.03 OTHER REVENUE	B	-1,401	OPERATING ROOM	50.00	0	36.03
36.04 OTHER REVENUE	B	-17,102	LABORATORY	60.00	0	36.04
36.05 OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	36.05
(3)						
36.06 OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	36.06
(3)						
36.07 MILLENIUM BLDG-1ST FLOOR	A	-91,976	ADMINISTRATIVE & GENERAL	5.00	0	36.07
36.08 MEDICAID ASSESSMENT TAX	A	-6,365,172	ADMINISTRATIVE & GENERAL	5.00	0	36.08
36.09 SPONSORSHIP EXP	A	-84,973	ADMINISTRATIVE & GENERAL	5.00	0	36.09
36.10 MIDWIFERY PROGRAM	A	-1,289,067	DELIVERY ROOM & LABOR ROOM	52.00	0	36.10
36.11 IHA - NON ALLOWABLE DUES	A	-28,320	ADMINISTRATIVE & GENERAL	5.00	0	36.11
50.00 TOTAL (sum of lines 1 thru 49)		-17,684,127				50.00
(Transfer to Worksheet A, column 6, line 200.)						

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0095

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

Worksheet A-8-2

Date/Time Prepared:
1/28/2021 12:08 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	22.00	AGGREGATE-I&R SERVICES-OTHER PRGM CO	2,184,238	1,729,814	454,424	211,500	3,985	1.00
2.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	503,164	459,991	43,173	197,500	596	2.00
3.00	31.00	AGGREGATE-INTENSIVE CARE UNIT	130,613	0	130,613	197,500	1,126	3.00
4.00	40.00	AGGREGATE-SUBPROVIDER - IPF	526,538	0	526,538	181,300	4,539	4.00
5.00	43.00	AGGREGATE-NURSERY	720,872	720,872	0	0	0	5.00
6.00	50.00	AGGREGATE-OPERATING ROOM	1,486,336	248,254	1,238,082	246,400	10,673	6.00
7.00	52.00	AGGREGATE-DELIVERY ROOM & LABOR ROOM	1,011,042	1,011,042	0	0	0	7.00
8.00	53.00	AGGREGATE-ANESTHESIOLOGY	1,730,694	1,730,694	0	0	0	8.00
9.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	1,806,061	0	1,806,061	271,900	15,569	9.00
10.00	57.00	AGGREGATE-CT SCAN	339,191	0	339,191	271,900	2,924	10.00
11.00	58.00	AGGREGATE-MRI	69,338	0	69,338	271,900	598	11.00
12.00	60.00	AGGREGATE-LABORATORY	6,000	0	6,000	260,300	52	12.00
13.00	66.00	AGGREGATE-PHYSICAL THERAPY	14,583	0	14,583	197,500	126	13.00
14.00	90.00	AGGREGATE-CLINIC	568,257	0	568,257	197,500	5,573	14.00
15.00	90.01	AGGREGATE-CHEMOTHERAPY	48,437	48,437	0	0	0	15.00
16.00	91.00	AGGREGATE-EMERGENCY	2,338,110	2,338,110	0	0	0	16.00
200.00			13,483,474	8,287,214	5,196,260		45,761	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	22.00	AGGREGATE-I&R SERVICES-OTHER PRGM CO	405,205	20,260	0	0	0	1.00
2.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	56,591	2,830	0	0	0	2.00
3.00	31.00	AGGREGATE-INTENSIVE CARE UNIT	106,916	5,346	0	0	0	3.00
4.00	40.00	AGGREGATE-SUBPROVIDER - IPF	395,635	19,782	0	0	0	4.00
5.00	43.00	AGGREGATE-NURSERY	0	0	0	0	0	5.00
6.00	50.00	AGGREGATE-OPERATING ROOM	1,264,340	63,217	0	0	0	6.00
7.00	52.00	AGGREGATE-DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	7.00
8.00	53.00	AGGREGATE-ANESTHESIOLOGY	0	0	0	0	0	8.00
9.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	2,035,198	101,760	0	0	0	9.00
10.00	57.00	AGGREGATE-CT SCAN	382,229	19,111	0	0	0	10.00
11.00	58.00	AGGREGATE-MRI	78,171	3,909	0	0	0	11.00
12.00	60.00	AGGREGATE-LABORATORY	6,508	325	0	0	0	12.00
13.00	66.00	AGGREGATE-PHYSICAL THERAPY	11,964	598	0	0	0	13.00
14.00	90.00	AGGREGATE-CLINIC	529,167	26,458	0	0	0	14.00
15.00	90.01	AGGREGATE-CHEMOTHERAPY	0	0	0	0	0	15.00
16.00	91.00	AGGREGATE-EMERGENCY	0	0	0	0	0	16.00
200.00			5,271,924	263,596	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	22.00	AGGREGATE-I&R SERVICES-OTHER PRGM CO	0	405,205	49,219	1,779,033		1.00
2.00	30.00	AGGREGATE-ADULTS & PEDIATRICS	0	56,591	0	459,991		2.00
3.00	31.00	AGGREGATE-INTENSIVE CARE UNIT	0	106,916	23,697	23,697		3.00
4.00	40.00	AGGREGATE-SUBPROVIDER - IPF	0	395,635	130,903	130,903		4.00
5.00	43.00	AGGREGATE-NURSERY	0	0	0	720,872		5.00
6.00	50.00	AGGREGATE-OPERATING ROOM	0	1,264,340	0	248,254		6.00
7.00	52.00	AGGREGATE-DELIVERY ROOM & LABOR ROOM	0	0	0	1,011,042		7.00
8.00	53.00	AGGREGATE-ANESTHESIOLOGY	0	0	0	1,730,694		8.00
9.00	54.00	AGGREGATE-RADIOLOGY-DIAGNOSTIC	0	2,035,198	0	0		9.00
10.00	57.00	AGGREGATE-CT SCAN	0	382,229	0	0		10.00
11.00	58.00	AGGREGATE-MRI	0	78,171	0	0		11.00
12.00	60.00	AGGREGATE-LABORATORY	0	6,508	0	0		12.00
13.00	66.00	AGGREGATE-PHYSICAL THERAPY	0	11,964	2,619	2,619		13.00
14.00	90.00	AGGREGATE-CLINIC	0	529,167	39,090	39,090		14.00
15.00	90.01	AGGREGATE-CHEMOTHERAPY	0	0	0	48,437		15.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0095

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

Worksheet A-8-2

Date/Time Prepared:
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	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		
16.00	91.00	AGGREGATE-EMERGENCY	0	0	0	2,338,110		16.00
200.00			0	5,271,924	245,528	8,532,742		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0095

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part I
Date/Time Prepared:
1/28/2021 12:08 pm

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	4.00	4A
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	2,481,547	2,481,547			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0		0		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	7,459,508	9,759	0	7,469,267	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	30,336,143	306,128	0	1,751,887	32,394,158
6.00	00600	MAINTENANCE & REPAIRS	1,960,244	92,732	0	58,846	2,111,822
7.00	00700	OPERATION OF PLANT	2,852,674	305,981	0	166,392	3,325,047
8.00	00800	LAUNDRY & LINEN SERVICE	0	43,262	0	0	43,262
9.00	00900	HOUSEKEEPING	1,933,822	22,274	0	109,441	2,065,537
10.00	01000	DIETARY	1,439,363	44,903	0	73,162	1,557,428
11.00	01100	CAFETERIA	386,822	62,181	0	57,613	506,616
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	1,227,376	43,433	0	144,432	1,415,241
14.00	01400	CENTRAL SERVICES & SUPPLY	480,329	64,042	0	42,176	586,547
15.00	01500	PHARMACY	875,365	35,413	0	198,103	1,108,881
16.00	01600	MEDICAL RECORDS & LIBRARY	1,177,480	45,246	0	93,444	1,316,170
17.00	01700	SOCIAL SERVICE	880,685	12,221	0	102,036	994,942
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	1,030,112	0	0	276,163	1,306,275
23.00	02300	PARAMED ED PRGM- (SPECIFY)	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	6,083,300	516,069	0	754,992	7,354,361
31.00	03100	INTENSIVE CARE UNIT	2,308,043	70,214	0	272,320	2,650,577
40.00	04000	SUBPROVIDER - IPF	3,238,532	154,374	0	324,865	3,717,771
43.00	04300	NURSERY	908,620	15,527	0	183,919	1,108,066
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,100,566	70,997	0	163,840	3,335,403
51.00	05100	RECOVERY ROOM	319,350	0	0	39,125	358,475
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,486,292	47,548	0	561,565	3,095,405
53.00	05300	ANESTHESIOLOGY	287,770	9,159	0	209,361	506,290
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,448,956	131,623	0	275,538	4,856,117
57.00	05700	CT SCAN	818,203	0	0	56,059	874,262
58.00	05800	MRI	212,171	0	0	17,476	229,647
60.00	06000	LABORATORY	3,335,199	87,295	0	191,756	3,614,250
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	521,885	0	0	672	522,557
65.00	06500	RESPIRATORY THERAPY	692,917	16,078	0	84,003	792,998
66.00	06600	PHYSICAL THERAPY	1,034,570	21,160	0	122,856	1,178,586
69.00	06900	ELECTROCARDIOLOGY	502,485	12,270	0	47,225	561,980
70.00	07000	ELECTROENCEPHALOGRAPHY	54,062	7,751	0	6,583	68,396
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,379,237	0	0	0	3,379,237
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	678,854	0	0	0	678,854
73.00	07300	DRUGS CHARGED TO PATIENTS	3,051,396	0	0	0	3,051,396
75.00	07500	ASC (NON-DISTINCT PART)	449,595	0	0	54,547	504,142
76.00	03951	HEMODIALYSIS	406,190	0	0	247	406,437
76.01	03952	DIABETES CENTER	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	2,775,243	73,985	0	241,458	3,090,686
90.01	09001	CHEMOTHERAPY	371,929	0	0	47,346	419,275
90.02	09002	KEDZIE CLINIC	568,367	0	0	59,807	628,174
90.03	09003	LITTLE VILLAGE CLINIC	1,308,276	0	0	84,808	1,393,084
91.00	09100	EMERGENCY	3,561,339	45,491	0	417,066	4,023,896
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	101,424,817	2,367,116	0	7,291,129	101,132,248
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	67,410	1,837	0	4,088	73,335
192.00	19200	PHYSICIANS' PRIVATE OFFICES	983,308	112,594	0	80,051	1,175,953
192.01	19201	OTHER NON-REIMBURSABLE	177,532	0	0	21,441	198,973
192.02	19202	NEPHROLOGY	1,503,562	0	0	72,558	1,576,120

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0095

Period:
From 07/01/2019
To 06/30/2020Worksheet B
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Cost Center Description			Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						0 200.00
201.00		Negative Cost Centers		0	0	0	0	0 201.00
202.00		TOTAL (sum lines 118 through 201)	104,156,629	2,481,547	0	7,469,267	104,156,629	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0095

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part I
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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	32,394,158					5.00
6.00	00600	MAINTENANCE & REPAIRS	953,293	3,065,115				6.00
7.00	00700	OPERATION OF PLANT	1,500,953	452,436	5,278,436			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	19,529	63,969	129,238	255,998		8.00
9.00	00900	HOUSEKEEPING	932,400	32,935	66,539	0	3,097,411	9.00
10.00	01000	DIETARY	703,035	66,395	134,139	0	81,745	10.00
11.00	01100	CAFETERIA	228,691	91,943	185,754	0	113,200	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	638,851	64,222	129,750	0	79,070	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	264,772	94,695	191,314	0	116,588	14.00
15.00	01500	PHARMACY	500,558	52,363	105,790	0	64,469	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	594,130	66,902	135,163	0	82,370	16.00
17.00	01700	SOCIAL SERVICE	449,125	18,070	36,507	0	22,248	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	589,663	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	3,319,820	763,085	1,541,668	124,889	939,503	30.00
31.00	03100	INTENSIVE CARE UNIT	1,196,492	103,821	209,750	30,206	127,823	31.00
40.00	04000	SUBPROVIDER - IPF	1,678,232	228,264	461,165	75,563	281,038	40.00
43.00	04300	NURSERY	500,190	22,959	46,384	25,340	28,267	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,505,628	104,979	212,091	0	129,250	50.00
51.00	05100	RECOVERY ROOM	161,818	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,397,291	70,306	142,041	0	86,561	52.00
53.00	05300	ANESTHESIOLOGY	228,543	13,543	27,362	0	16,675	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,192,090	194,623	393,200	0	239,619	54.00
57.00	05700	CT SCAN	394,649	0	0	0	0	57.00
58.00	05800	MRI	103,664	0	0	0	0	58.00
60.00	06000	LABORATORY	1,631,501	129,079	260,780	0	158,921	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	235,886	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	357,966	23,773	48,030	0	29,270	65.00
66.00	06600	PHYSICAL THERAPY	532,023	31,287	63,210	0	38,521	66.00
69.00	06900	ELECTROCARDIOLOGY	253,682	18,142	36,653	0	22,337	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	30,875	11,461	23,155	0	14,111	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,525,415	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	306,440	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,377,425	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	227,574	0	0	0	0	75.00
76.00	03951	HEMODIALYSIS	183,469	0	0	0	0	76.00
76.01	03952	DIABETES CENTER	0	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1,395,160	109,397	221,017	0	134,689	90.00
90.01	09001	CHEMOTHERAPY	189,264	0	0	0	0	90.01
90.02	09002	KEDZIE CLINIC	283,563	0	0	0	0	90.02
90.03	09003	LITTLE VILLAGE CLINIC	628,849	0	0	0	0	90.03
91.00	09100	EMERGENCY	1,816,419	67,264	135,895	0	82,815	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	31,028,928	2,895,913	4,936,595	255,998	2,889,090	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	33,104	2,716	5,487	0	3,344	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	530,835	166,486	336,354	0	204,977	192.00
192.01	19201	OTHER NON-REIMBURSABLE	89,818	0	0	0	0	192.01
192.02	19202	NEPHROLOGY	711,473	0	0	0	0	192.02
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	32,394,158	3,065,115	5,278,436	255,998	3,097,411	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0095

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part I
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Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	2,542,742					10.00
11.00	01100	CAFETERIA	0	1,126,204				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	50,372	0	2,377,506		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	14,240	0	0	1,268,156	14.00
15.00	01500	PHARMACY	0	40,731	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	23,461	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	20,852	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	21,803	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,399,422	181,367	0	593,672	0	30.00
31.00	03100	INTENSIVE CARE UNIT	326,516	59,814	0	195,791	0	31.00
40.00	04000	SUBPROVIDER - IPF	816,804	90,992	0	297,849	0	40.00
43.00	04300	NURSERY	0	28,857	0	94,457	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	39,935	0	130,720	0	50.00
51.00	05100	RECOVERY ROOM	0	4,997	0	16,358	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	97,117	0	317,898	0	52.00
53.00	05300	ANESTHESIOLOGY	0	13,953	0	45,673	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	73,059	0	0	0	54.00
57.00	05700	CT SCAN	0	8,646	0	0	0	57.00
58.00	05800	MRI	0	4,356	0	0	0	58.00
60.00	06000	LABORATORY	0	54,706	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	199	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	25,849	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	32,439	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	10,901	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2,012	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	1,078,166	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	189,990	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	12,516	0	40,968	0	75.00
76.00	03951	HEMODIALYSIS	0	0	0	0	0	76.00
76.01	03952	DIABETES CENTER	0	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	66,890	0	218,953	0	90.00
90.01	09001	CHEMOTHERAPY	0	7,607	0	24,899	0	90.01
90.02	09002	KEDZIE CLINIC	0	0	0	0	0	90.02
90.03	09003	LITTLE VILLAGE CLINIC	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	122,281	0	400,268	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,542,742	1,109,952	0	2,377,506	1,268,156	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	22	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	OTHER NON-REIMBURSABLE	0	16,230	0	0	0	192.01
192.02	19202	NEPHROLOGY	0	0	0	0	0	192.02
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	2,542,742	1,126,204	0	2,377,506	1,268,156	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0095

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part I
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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	1,872,792					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,218,196				16.00
17.00	01700	SOCIAL SERVICE	0	0	1,541,744			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	223,702	752,140	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	231	87,783	181,917	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	101,684	455,077	0	0	40.00
43.00	04300	NURSERY	0	32,767	152,610	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	31	107,221	0	0	0	50.00
51.00	05100	RECOVERY ROOM	4	5,915	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	68,481	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	573	39,678	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	155,619	0	0	0	54.00
57.00	05700	CT SCAN	0	139,060	0	0	0	57.00
58.00	05800	MRI	0	16,107	0	0	0	58.00
60.00	06000	LABORATORY	0	196,956	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	22,840	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	111,514	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	38,511	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	34,447	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	8,012	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	47,399	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	14,247	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,870,802	261,922	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	3,539	0	0	0	75.00
76.00	03951	HEMODIALYSIS	0	4,262	0	0	0	76.00
76.01	03952	DIABETES CENTER	0	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	84,463	0	0	0	90.00
90.01	09001	CHEMOTHERAPY	0	12,225	0	0	0	90.01
90.02	09002	KEDZIE CLINIC	0	26,586	0	0	0	90.02
90.03	09003	LITTLE VILLAGE CLINIC	0	41,682	0	0	0	90.03
91.00	09100	EMERGENCY	1,151	331,574	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,872,792	2,218,196	1,541,744	0	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	OTHER NON-REIMBURSABLE	0	0	0	0	0	192.01
192.02	19202	NEPHROLOGY	0	0	0	0	0	192.02
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	1,872,792	2,218,196	1,541,744	0	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0095

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part I
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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	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE						17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS						19.00
20.00	02000	NURSING SCHOOL						20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		1,917,741				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)			0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	767,097	0	17,960,726	-767,097	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	5,170,721	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	8,204,439	0	40.00
43.00	04300	NURSERY	0	0	0	2,039,897	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	5,565,258	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	547,567	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	5,275,100	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	892,290	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	8,104,327	0	54.00
57.00	05700	CT SCAN	0	0	0	1,416,617	0	57.00
58.00	05800	MRI	0	0	0	353,774	0	58.00
60.00	06000	LABORATORY	0	0	0	6,046,193	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	781,482	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	1,389,400	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	1,914,577	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	938,142	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	158,022	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	6,030,217	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,189,531	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	6,561,545	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	788,739	0	75.00
76.00	03951	HEMODIALYSIS	0	0	0	594,168	0	76.00
76.01	03952	DIABETES CENTER	0	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	383,548	0	5,704,803	-383,548	90.00
90.01	09001	CHEMOTHERAPY	0	0	0	653,270	0	90.01
90.02	09002	KEDZIE CLINIC	0	0	0	938,323	0	90.02
90.03	09003	LITTLE VILLAGE CLINIC	0	0	0	2,063,615	0	90.03
91.00	09100	EMERGENCY	0	767,096	0	7,748,659	-767,096	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
OTHER REIMBURSABLE COST CENTERS								
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	1,917,741	0	99,031,402	-1,917,741	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	118,008	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	2,414,605	0	192.00
192.01	19201	OTHER NON-REIMBURSABLE	0	0	0	305,021	0	192.01
192.02	19202	NEPHROLOGY	0	0	0	2,287,593	0	192.02

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0095

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part I
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	
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	1,917,741	0	104,156,629	-1,917,741	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0095

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From 07/01/2019
To 06/30/2020Worksheet B
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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	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
40.00	04000	SUBPROVIDER - IPF	40.00
43.00	04300	NURSERY	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
51.00	05100	RECOVERY ROOM	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
57.00	05700	CT SCAN	57.00
58.00	05800	MRI	58.00
60.00	06000	LABORATORY	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	63.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
75.00	07500	ASC (NON-DISTINCT PART)	75.00
76.00	03951	HEMODIALYSIS	76.00
76.01	03952	DIABETES CENTER	76.01
76.97	07697	CARDIAC REHABILITATION	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	76.98
76.99	07699	LITHOTRIPSY	76.99
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
90.01	09001	CHEMOTHERAPY	90.01
90.02	09002	KEDZIE CLINIC	90.02
90.03	09003	LITTLE VILLAGE CLINIC	90.03
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
OTHER REIMBURSABLE COST CENTERS			
99.20	09920	OUTPATIENT PHYSICAL THERAPY	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	99.40
SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
192.01	19201	OTHER NON-REIMBURSABLE	192.01
192.02	19202	NEPHROLOGY	192.02
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	194.00
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0095

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part II
Date/Time Prepared:
1/28/2021 12:08 pm

Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	9,759	0	9,759	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	306,128	0	306,128	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	92,732	0	92,732	6.00
7.00	00700	OPERATION OF PLANT	0	305,981	0	305,981	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	43,262	0	43,262	8.00
9.00	00900	HOUSEKEEPING	0	22,274	0	22,274	9.00
10.00	01000	DIETARY	0	44,903	0	44,903	10.00
11.00	01100	CAFETERIA	0	62,181	0	62,181	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	43,433	0	43,433	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	64,042	0	64,042	14.00
15.00	01500	PHARMACY	0	35,413	0	35,413	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	45,246	0	45,246	16.00
17.00	01700	SOCIAL SERVICE	0	12,221	0	12,221	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	516,069	0	516,069	30.00
31.00	03100	INTENSIVE CARE UNIT	0	70,214	0	70,214	31.00
40.00	04000	SUBPROVIDER - IPF	0	154,374	0	154,374	40.00
43.00	04300	NURSERY	0	15,527	0	15,527	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	70,997	0	70,997	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	47,548	0	47,548	52.00
53.00	05300	ANESTHESIOLOGY	0	9,159	0	9,159	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	131,623	0	131,623	54.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
60.00	06000	LABORATORY	0	87,295	0	87,295	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	16,078	0	16,078	65.00
66.00	06600	PHYSICAL THERAPY	0	21,160	0	21,160	66.00
69.00	06900	ELECTROCARDIOLOGY	0	12,270	0	12,270	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	7,751	0	7,751	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
76.00	03951	HEMODIALYSIS	0	0	0	0	76.00
76.01	03952	DIABETES CENTER	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	73,985	0	73,985	90.00
90.01	09001	CHEMOTHERAPY	0	0	0	0	90.01
90.02	09002	KEDZIE CLINIC	0	0	0	0	90.02
90.03	09003	LITTLE VILLAGE CLINIC	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	45,491	0	45,491	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	2,367,116	0	2,367,116	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,837	0	1,837	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	112,594	0	112,594	192.00
192.01	19201	OTHER NON-REIMBURSABLE	0	0	0	0	192.01
192.02	19202	NEPHROLOGY	0	0	0	0	192.02
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0095

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description		Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			BLDG & FIXT	MVBLE EQUIP			
		0	1.00	2.00	2A	4.00	
200.00	Cross Foot Adjustments				0		200.00
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	0	2,481,547	0	2,481,547	9,759	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0095

Period:
From 07/01/2019
To 06/30/2020Worksheet B
Part II
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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	308,406					5.00
6.00	00600	MAINTENANCE & REPAIRS	9,077	101,886				6.00
7.00	00700	OPERATION OF PLANT	14,291	15,039	335,529			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	186	2,126	8,215	53,789		8.00
9.00	00900	HOUSEKEEPING	8,878	1,095	4,230	0	36,620	9.00
10.00	01000	DIETARY	6,694	2,207	8,527	0	966	10.00
11.00	01100	CAFETERIA	2,177	3,056	11,808	0	1,338	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	6,083	2,135	8,248	0	935	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	2,521	3,148	12,161	0	1,378	14.00
15.00	01500	PHARMACY	4,766	1,741	6,725	0	762	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,657	2,224	8,592	0	974	16.00
17.00	01700	SOCIAL SERVICE	4,276	601	2,321	0	263	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	5,614	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	31,579	25,365	97,996	26,241	11,110	30.00
31.00	03100	INTENSIVE CARE UNIT	11,392	3,451	13,333	6,347	1,511	31.00
40.00	04000	SUBPROVIDER - IPF	15,979	7,588	29,314	15,877	3,323	40.00
43.00	04300	NURSERY	4,762	763	2,948	5,324	334	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	14,336	3,490	13,482	0	1,528	50.00
51.00	05100	RECOVERY ROOM	1,541	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	13,304	2,337	9,029	0	1,023	52.00
53.00	05300	ANESTHESIOLOGY	2,176	450	1,739	0	197	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	20,872	6,469	24,994	0	2,833	54.00
57.00	05700	CT SCAN	3,758	0	0	0	0	57.00
58.00	05800	MRI	987	0	0	0	0	58.00
60.00	06000	LABORATORY	15,534	4,291	16,577	0	1,879	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,246	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	3,408	790	3,053	0	346	65.00
66.00	06600	PHYSICAL THERAPY	5,066	1,040	4,018	0	455	66.00
69.00	06900	ELECTROCARDIOLOGY	2,415	603	2,330	0	264	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	294	381	1,472	0	167	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	14,524	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,918	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	13,115	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	2,167	0	0	0	0	75.00
76.00	03951	HEMODIALYSIS	1,747	0	0	0	0	76.00
76.01	03952	DIABETES CENTER	0	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	13,284	3,636	14,049	0	1,592	90.00
90.01	09001	CHEMOTHERAPY	1,802	0	0	0	0	90.01
90.02	09002	KEDZIE CLINIC	2,700	0	0	0	0	90.02
90.03	09003	LITTLE VILLAGE CLINIC	5,987	0	0	0	0	90.03
91.00	09100	EMERGENCY	17,295	2,236	8,638	0	979	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	295,408	96,262	313,799	53,789	34,157	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	315	90	349	0	40	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,054	5,534	21,381	0	2,423	192.00
192.01	19201	OTHER NON-REIMBURSABLE	855	0	0	0	0	192.01
192.02	19202	NEPHROLOGY	6,774	0	0	0	0	192.02
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	308,406	101,886	335,529	53,789	36,620	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0095

Period:
From 07/01/2019
To 06/30/2020Worksheet B
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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	63,393					10.00
11.00	01100	CAFETERIA	0	80,635				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	3,607	0	64,630		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,020	0	0	84,325	14.00
15.00	01500	PHARMACY	0	2,916	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	1,680	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	1,493	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	1,561	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	34,889	12,983	0	16,137	0	30.00
31.00	03100	INTENSIVE CARE UNIT	8,140	4,283	0	5,322	0	31.00
40.00	04000	SUBPROVIDER - IPF	20,364	6,515	0	8,097	0	40.00
43.00	04300	NURSERY	0	2,066	0	2,568	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	2,859	0	3,553	0	50.00
51.00	05100	RECOVERY ROOM	0	358	0	445	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	6,954	0	8,642	0	52.00
53.00	05300	ANESTHESIOLOGY	0	999	0	1,242	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,231	0	0	0	54.00
57.00	05700	CT SCAN	0	619	0	0	0	57.00
58.00	05800	MRI	0	312	0	0	0	58.00
60.00	06000	LABORATORY	0	3,917	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	14	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	1,851	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	2,323	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	781	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	144	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71,692	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	12,633	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	896	0	1,114	0	75.00
76.00	03951	HEMODIALYSIS	0	0	0	0	0	76.00
76.01	03952	DIABETES CENTER	0	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	4,789	0	5,952	0	90.00
90.01	09001	CHEMOTHERAPY	0	545	0	677	0	90.01
90.02	09002	KEDZIE CLINIC	0	0	0	0	0	90.02
90.03	09003	LITTLE VILLAGE CLINIC	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	8,755	0	10,881	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	63,393	79,471	0	64,630	84,325	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	OTHER NON-REIMBURSABLE	0	1,162	0	0	0	192.01
192.02	19202	NEPHROLOGY	0	0	0	0	0	192.02
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	63,393	80,635	0	64,630	84,325	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0095

Period:
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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	52,582					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	64,495				16.00
17.00	01700	SOCIAL SERVICE	0	0	21,309			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	10,396			30.00
31.00	03100	INTENSIVE CARE UNIT	6	2,556	2,514			31.00
40.00	04000	SUBPROVIDER - IPF	0	2,961	6,290			40.00
43.00	04300	NURSERY	0	954	2,109			43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1	3,122	0			50.00
51.00	05100	RECOVERY ROOM	0	172	0			51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,994	0			52.00
53.00	05300	ANESTHESIOLOGY	16	1,155	0			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,532	0			54.00
57.00	05700	CT SCAN	0	4,049	0			57.00
58.00	05800	MRI	0	469	0			58.00
60.00	06000	LABORATORY	0	5,735	0			60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0			62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	665	0			63.00
65.00	06500	RESPIRATORY THERAPY	0	3,247	0			65.00
66.00	06600	PHYSICAL THERAPY	0	1,121	0			66.00
69.00	06900	ELECTROCARDIOLOGY	0	1,003	0			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	233	0			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,380	0			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	415	0			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	52,527	7,627	0			73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	103	0			75.00
76.00	03951	HEMODIALYSIS	0	124	0			76.00
76.01	03952	DIABETES CENTER	0	0	0			76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0			76.98
76.99	07699	LITHOTRIPSY	0	0	0			76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	2,460	0			90.00
90.01	09001	CHEMOTHERAPY	0	356	0			90.01
90.02	09002	KEDZIE CLINIC	0	774	0			90.02
90.03	09003	LITTLE VILLAGE CLINIC	0	1,214	0			90.03
91.00	09100	EMERGENCY	32	9,560	0			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0			99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0			99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0			99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	52,582	64,495	21,309	0	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0			190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0			192.00
192.01	19201	OTHER NON-REIMBURSABLE	0	0	0			192.01
192.02	19202	NEPHROLOGY	0	0	0			192.02
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0			194.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	52,582	64,495	21,309	0	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0095

Period:
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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	
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		7,536				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)			0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS				790,267	0	30.00
31.00	03100	INTENSIVE CARE UNIT				129,425	0	31.00
40.00	04000	SUBPROVIDER - IPF				271,107	0	40.00
43.00	04300	NURSERY				37,596	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM				113,582	0	50.00
51.00	05100	RECOVERY ROOM				2,567	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM				91,566	0	52.00
53.00	05300	ANESTHESIOLOGY				17,407	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC				196,915	0	54.00
57.00	05700	CT SCAN				8,499	0	57.00
58.00	05800	MRI				1,791	0	58.00
60.00	06000	LABORATORY				135,479	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS				0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.				2,926	0	63.00
65.00	06500	RESPIRATORY THERAPY				28,883	0	65.00
66.00	06600	PHYSICAL THERAPY				35,344	0	66.00
69.00	06900	ELECTROCARDIOLOGY				19,728	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY				10,451	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT				87,596	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS				15,966	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS				73,269	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)				4,351	0	75.00
76.00	03951	HEMODIALYSIS				1,871	0	76.00
76.01	03952	DIABETES CENTER				0	0	76.01
76.97	07697	CARDIAC REHABILITATION				0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY				0	0	76.98
76.99	07699	LITHOTRIPSY				0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC				120,063	0	90.00
90.01	09001	CHEMOTHERAPY				3,442	0	90.01
90.02	09002	KEDZIE CLINIC				3,552	0	90.02
90.03	09003	LITTLE VILLAGE CLINIC				7,312	0	90.03
91.00	09100	EMERGENCY				104,413	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
OTHER REIMBURSABLE COST CENTERS								
99.20	09920	OUTPATIENT PHYSICAL THERAPY				0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY				0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY				0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	2,315,368	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN				2,638	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES				147,091	0	192.00
192.01	19201	OTHER NON-REIMBURSABLE				2,045	0	192.01
192.02	19202	NEPHROLOGY				6,869	0	192.02

ALLOCATION OF CAPITAL RELATED COSTS

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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				
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS				0	0	194.00
200.00		Cross Foot Adjustments	0	7,536	0	7,536	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	7,536	0	2,481,547	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0095

Period:
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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	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
40.00	04000	SUBPROVIDER - IPF	40.00
43.00	04300	NURSERY	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
51.00	05100	RECOVERY ROOM	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
57.00	05700	CT SCAN	57.00
58.00	05800	MRI	58.00
60.00	06000	LABORATORY	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	63.00
65.00	06500	RESPIRATORY THERAPY	65.00
66.00	06600	PHYSICAL THERAPY	66.00
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
75.00	07500	ASC (NON-DISTINCT PART)	75.00
76.00	03951	HEMODIALYSIS	76.00
76.01	03952	DIABETES CENTER	76.01
76.97	07697	CARDIAC REHABILITATION	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	76.98
76.99	07699	LITHOTRIPSY	76.99
OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	90.00
90.01	09001	CHEMOTHERAPY	90.01
90.02	09002	KEDZIE CLINIC	90.02
90.03	09003	LITTLE VILLAGE CLINIC	90.03
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
OTHER REIMBURSABLE COST CENTERS			
99.20	09920	OUTPATIENT PHYSICAL THERAPY	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	99.40
SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	118.00
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	192.00
192.01	19201	OTHER NON-REIMBURSABLE	192.01
192.02	19202	NEPHROLOGY	192.02
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	194.00
200.00		Cross Foot Adjustments	200.00
201.00		Negative Cost Centers	201.00
202.00		TOTAL (sum lines 118 through 201)	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0095

Period:
From 07/01/2019
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 (SQUARE FEET)				
		1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	202,656				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		202,656			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	797	797	56,825,594		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	25,000	25,000	13,328,237	-32,394,158	5.00
6.00	00600	MAINTENANCE & REPAIRS	7,573	7,573	447,695	0	6.00
7.00	00700	OPERATION OF PLANT	24,988	24,988	1,265,894	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,533	3,533	0	0	8.00
9.00	00900	HOUSEKEEPING	1,819	1,819	832,616	0	9.00
10.00	01000	DIETARY	3,667	3,667	556,613	0	10.00
11.00	01100	CAFETERIA	5,078	5,078	438,315	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	3,547	3,547	1,098,825	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,230	5,230	320,872	0	14.00
15.00	01500	PHARMACY	2,892	2,892	1,507,149	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,695	3,695	710,918	0	16.00
17.00	01700	SOCIAL SERVICE	998	998	776,282	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	2,101,027	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	42,145	42,145	5,743,917	0	30.00
31.00	03100	INTENSIVE CARE UNIT	5,734	5,734	2,071,790	0	31.00
40.00	04000	SUBPROVIDER - IPF	12,607	12,607	2,471,549	0	40.00
43.00	04300	NURSERY	1,268	1,268	1,399,239	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	5,798	5,798	1,246,483	0	50.00
51.00	05100	RECOVERY ROOM	0	0	297,662	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,883	3,883	4,272,343	0	52.00
53.00	05300	ANESTHESIOLOGY	748	748	1,592,803	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,749	10,749	2,096,270	0	54.00
57.00	05700	CT SCAN	0	0	426,494	0	57.00
58.00	05800	MRI	0	0	132,959	0	58.00
60.00	06000	LABORATORY	7,129	7,129	1,458,861	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	5,115	0	63.00
65.00	06500	RESPIRATORY THERAPY	1,313	1,313	639,085	0	65.00
66.00	06600	PHYSICAL THERAPY	1,728	1,728	934,675	0	66.00
69.00	06900	ELECTROCARDIOLOGY	1,002	1,002	359,287	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	633	633	50,080	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	414,988	0	75.00
76.00	03951	HEMODIALYSIS	0	0	1,879	0	76.00
76.01	03952	DIABETES CENTER	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	6,042	6,042	1,836,995	0	90.00
90.01	09001	CHEMOTHERAPY	0	0	360,205	0	90.01
90.02	09002	KEDZIE CLINIC	0	0	455,006	0	90.02
90.03	09003	LITTLE VILLAGE CLINIC	0	0	645,209	0	90.03
91.00	09100	EMERGENCY	3,715	3,715	3,173,002	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS							
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	193,311	193,311	55,470,339	-32,394,158	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	150	150	31,103	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	9,195	9,195	609,021	0	192.00
192.01	19201	OTHER NON-REIMBURSABLE	0	0	163,118	0	192.01
192.02	19202	NEPHROLOGY	0	0	552,013	0	192.02

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0095

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 (SQUARE FEET)				
			1.00	2.00	4.00	5A	5.00	
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,481,547	0	7,469,267		32,394,158	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	12.245120	0.000000	0.131442		0.451408	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			9,759		308,406	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000172		0.004298	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0095

Period:
From 07/01/2019
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 (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	169,286					6.00
7.00	00700	OPERATION OF PLANT	24,988	144,298				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,533	3,533	29,671			8.00
9.00	00900	HOUSEKEEPING	1,819	1,819	0	138,946		9.00
10.00	01000	DIETARY	3,667	3,667	0	3,667	81,792	10.00
11.00	01100	CAFETERIA	5,078	5,078	0	5,078	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	3,547	3,547	0	3,547	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,230	5,230	0	5,230	0	14.00
15.00	01500	PHARMACY	2,892	2,892	0	2,892	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,695	3,695	0	3,695	0	16.00
17.00	01700	SOCIAL SERVICE	998	998	0	998	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	42,145	42,145	14,475	42,145	45,015	30.00
31.00	03100	INTENSIVE CARE UNIT	5,734	5,734	3,501	5,734	10,503	31.00
40.00	04000	SUBPROVIDER - IPF	12,607	12,607	8,758	12,607	26,274	40.00
43.00	04300	NURSERY	1,268	1,268	2,937	1,268	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	5,798	5,798	0	5,798	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,883	3,883	0	3,883	0	52.00
53.00	05300	ANESTHESIOLOGY	748	748	0	748	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,749	10,749	0	10,749	0	54.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
60.00	06000	LABORATORY	7,129	7,129	0	7,129	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	1,313	1,313	0	1,313	0	65.00
66.00	06600	PHYSICAL THERAPY	1,728	1,728	0	1,728	0	66.00
69.00	06900	ELECTROCARDIOLOGY	1,002	1,002	0	1,002	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	633	633	0	633	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
76.00	03951	HEMODIALYSIS	0	0	0	0	0	76.00
76.01	03952	DIABETES CENTER	0	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	6,042	6,042	0	6,042	0	90.00
90.01	09001	CHEMOTHERAPY	0	0	0	0	0	90.01
90.02	09002	KEDZIE CLINIC	0	0	0	0	0	90.02
90.03	09003	LITTLE VILLAGE CLINIC	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	3,715	3,715	0	3,715	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	159,941	134,953	29,671	129,601	81,792	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	150	150	0	150	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	9,195	9,195	0	9,195	0	192.00
192.01	19201	OTHER NON-REIMBURSABLE	0	0	0	0	0	192.01
192.02	19202	NEPHROLOGY	0	0	0	0	0	192.02
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0095

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

Worksheet B-1

Date/Time Prepared:
1/28/2021 12:08 pm

Cost Center Description			MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (TOTAL PATIENT DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
			6.00	7.00	8.00	9.00	10.00	
202.00		Cost to be allocated (per Wkst. B, Part I)	3,065,115	5,278,436	255,998	3,097,411	2,542,742	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	18.106134	36.580105	8.627886	22.292193	31.087906	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	101,886	335,529	53,789	36,620	63,393	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.601857	2.325251	1.812848	0.263556	0.775051	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0095

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

Worksheet B-1

Date/Time Prepared:
1/28/2021 12:08 pm

Cost Center Description			CAFETERIA (PROD FTE'S)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (NURS DIRECT FTE)	CENTRAL SERVICES & SUPPLY (COSTED REQUI)	PHARMACY (COSTED REQUI)	
			11.00	12.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	50,931					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	2,278	0	32,847			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	644	0	0	4,531,246		14.00
15.00	01500	PHARMACY	1,842	0	0	0	3,054,642	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,061	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	943	0	0	0	0	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	986	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	8,202	0	8,202	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	2,705	0	2,705	0	377	31.00
40.00	04000	SUBPROVIDER - IPF	4,115	0	4,115	0	0	40.00
43.00	04300	NURSERY	1,305	0	1,305	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,806	0	1,806	0	50	50.00
51.00	05100	RECOVERY ROOM	226	0	226	0	7	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,392	0	4,392	0	0	52.00
53.00	05300	ANESTHESIOLOGY	631	0	631	0	934	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,304	0	0	0	0	54.00
57.00	05700	CT SCAN	391	0	0	0	0	57.00
58.00	05800	MRI	197	0	0	0	0	58.00
60.00	06000	LABORATORY	2,474	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	9	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	1,169	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	1,467	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	493	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	91	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	3,852,392	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	678,854	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	3,051,396	73.00
75.00	07500	ASC (NON-DISTINCT PART)	566	0	566	0	0	75.00
76.00	03951	HEMODIALYSIS	0	0	0	0	0	76.00
76.01	03952	DIABETES CENTER	0	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	3,025	0	3,025	0	0	90.00
90.01	09001	CHEMOTHERAPY	344	0	344	0	0	90.01
90.02	09002	KEDZIE CLINIC	0	0	0	0	0	90.02
90.03	09003	LITTLE VILLAGE CLINIC	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	5,530	0	5,530	0	1,878	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	50,196	0	32,847	4,531,246	3,054,642	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	OTHER NON-REIMBURSABLE	734	0	0	0	0	192.01
192.02	19202	NEPHROLOGY	0	0	0	0	0	192.02
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0095

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

Worksheet B-1

Date/Time Prepared:
1/28/2021 12:08 pm

Cost Center Description		CAFETERIA (PROD FTE'S)	MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (NURS DIRECT FTE)	CENTRAL SERVICES & SUPPLY (COSTED REQUI)	PHARMACY (COSTED REQUI)	
		11.00	12.00	13.00	14.00	15.00	
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	1,126,204	0	2,377,506	1,268,156	1,872,792	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	22.112348	0.000000	72.381222	0.279869	0.613097	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	80,635	0	64,630	84,325	52,582	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	1.583220	0.000000	1.967607	0.018610	0.017214	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0095

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

Worksheet B-1

Date/Time Prepared:
1/28/2021 12:08 pm

Cost Center Description			MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-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	306,123,222					16.00
17.00	01700	SOCIAL SERVICE	0	29,671				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
20.00	02000	NURSING SCHOOL	0	0		0		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0			1,000	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0				23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	30,872,429	14,475	0	0	400	30.00
31.00	03100	INTENSIVE CARE UNIT	12,114,668	3,501	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	14,033,164	8,758	0	0	0	40.00
43.00	04300	NURSERY	4,522,020	2,937	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	14,797,318	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	816,376	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,450,895	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	5,475,880	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	21,476,572	0	0	0	0	54.00
57.00	05700	CT SCAN	19,191,231	0	0	0	0	57.00
58.00	05800	MRI	2,222,871	0	0	0	0	58.00
60.00	06000	LABORATORY	27,181,391	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	3,152,122	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	15,389,729	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	5,314,809	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	4,753,954	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,105,654	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,541,431	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,966,123	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	36,147,089	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	488,388	0	0	0	0	75.00
76.00	03951	HEMODIALYSIS	588,244	0	0	0	0	76.00
76.01	03952	DIABETES CENTER	0	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	11,656,446	0	0	0	200	90.00
90.01	09001	CHEMOTHERAPY	1,687,122	0	0	0	0	90.01
90.02	09002	KEDZIE CLINIC	3,669,078	0	0	0	0	90.02
90.03	09003	LITTLE VILLAGE CLINIC	5,752,440	0	0	0	0	90.03
91.00	09100	EMERGENCY	45,755,778	0	0	0	400	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	306,123,222	29,671	0	0	1,000	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	OTHER NON-REIMBURSABLE	0	0	0	0	0	192.01
192.02	19202	NEPHROLOGY	0	0	0	0	0	192.02

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0095

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

Worksheet B-1

Date/Time Prepared:
1/28/2021 12:08 pm

Cost Center Description			MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALAR Y & FRINGES APPRV (ASSIGNED TIME)	
			16.00	17.00	19.00	20.00	21.00	
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,218,196	1,541,744	0	0	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.007246	51.961309	0.000000	0.000000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	64,495	21,309	0	0	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000211	0.718176	0.000000	0.000000	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)				0		206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)				0.000000		207.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0095

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

Worksheet B-1

Date/Time Prepared:
1/28/2021 12:08 pm

Cost Center Description			INTERNS & RESIDENTS	PARAMED ED PRGM (ASSIGNED TIME)	
			SERVICES-OTHER		
			PRGM COSTS		
			APPRV (ASSIGNED TIME)		
			22.00	23.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
6.00	00600	MAINTENANCE & REPAIRS			6.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
12.00	01200	MAINTENANCE OF PERSONNEL			12.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS			19.00
20.00	02000	NURSING SCHOOL			20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	1,000		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)		0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	400	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	40.00
43.00	04300	NURSERY	0	0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	0	0	58.00
60.00	06000	LABORATORY	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	75.00
76.00	03951	HEMODIALYSIS	0	0	76.00
76.01	03952	DIABETES CENTER	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	200	0	90.00
90.01	09001	CHEMOTHERAPY	0	0	90.01
90.02	09002	KEDZIE CLINIC	0	0	90.02
90.03	09003	LITTLE VILLAGE CLINIC	0	0	90.03
91.00	09100	EMERGENCY	400	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
OTHER REIMBURSABLE COST CENTERS					
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	99.40
SPECIAL PURPOSE COST CENTERS					
118.00	SUBTOTALS (SUM OF LINES 1 through 117)		1,000	0	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
192.01	19201	OTHER NON-REIMBURSABLE	0	0	192.01
192.02	19202	NEPHROLOGY	0	0	192.02

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0095

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

Worksheet B-1

Date/Time Prepared:
1/28/2021 12:08 pm

Cost Center Description			INTERNS & RESIDENTS	PARAMED ED PRGM (ASSIGNED TIME)	
			SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)		
			22.00	23.00	
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	194.00
200.00		Cross Foot Adjustments			200.00
201.00		Negative Cost Centers			201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,917,741	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	1,917.741000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	7,536	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	7.536000	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

Worksheet C
Part I
Date/Time Prepared:
1/28/2021 12:08 pm

MCRIF32 - 16.6.170.2

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0095

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
1/28/2021 12:08 pm

			Title XVIII		Hospital	PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00	9.00	10.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	28,135,941		28,135,941		30.00
31.00	03100	INTENSIVE CARE UNIT	12,114,668		12,114,668		31.00
40.00	04000	SUBPROVIDER - IPF	14,033,164		14,033,164		40.00
43.00	04300	NURSERY	4,522,020		4,522,020		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,151,277	11,646,041	14,797,318	0.376099	50.00
51.00	05100	RECOVERY ROOM	242,200	574,176	816,376	0.670729	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,683,907	1,766,988	9,450,895	0.558159	52.00
53.00	05300	ANESTHESIOLOGY	2,235,773	3,240,107	5,475,880	0.162949	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,752,019	15,724,553	21,476,572	0.377357	54.00
57.00	05700	CT SCAN	5,002,790	14,188,441	19,191,231	0.073816	57.00
58.00	05800	MRI	635,398	1,587,473	2,222,871	0.159152	58.00
60.00	06000	LABORATORY	11,259,700	15,921,691	27,181,391	0.222439	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,323,927	828,195	3,152,122	0.247923	63.00
65.00	06500	RESPIRATORY THERAPY	14,656,540	733,189	15,389,729	0.090281	65.00
66.00	06600	PHYSICAL THERAPY	803,643	4,511,166	5,314,809	0.360234	66.00
69.00	06900	ELECTROCARDIOLOGY	1,934,262	2,819,692	4,753,954	0.197339	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	94,436	1,011,218	1,105,654	0.142922	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,904,440	2,636,991	6,541,431	0.921850	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,011,606	954,517	1,966,123	0.605014	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	19,311,677	16,835,412	36,147,089	0.181523	73.00
75.00	07500	ASC (NON-DISTINCT PART)	1,468	486,920	488,388	1.614984	75.00
76.00	03951	HEMODIALYSIS	548,338	39,906	588,244	1.010071	76.00
76.01	03952	DIABETES CENTER	0	0	0	0.000000	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	11,656,446	11,656,446	0.456507	90.00
90.01	09001	CHEMOTHERAPY	0	1,687,122	1,687,122	0.387210	90.01
90.02	09002	KEDZIE CLINIC	0	3,669,078	3,669,078	0.255738	90.02
90.03	09003	LITTLE VILLAGE CLINIC	0	5,752,440	5,752,440	0.358737	90.03
91.00	09100	EMERGENCY	7,767,139	37,988,639	45,755,778	0.152583	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	34,490	2,701,998	2,736,488	0.695589	92.00
OTHER REIMBURSABLE COST CENTERS							
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0		99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0		99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0		99.40
200.00		Subtotal (see instructions)	147,160,823	158,962,399	306,123,222		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	147,160,823	158,962,399	306,123,222		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0095	Period: From 07/01/2019 To 06/30/2020	Worksheet C Part I Date/Time Prepared: 1/28/2021 12:08 pm
			Title XVIII	Hospital	PPS
Cost Center Description			PPS Inpatient Ratio		
			11.00		
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.376099		50.00
51.00	05100	RECOVERY ROOM	0.670729		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.558159		52.00
53.00	05300	ANESTHESIOLOGY	0.162949		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.377357		54.00
57.00	05700	CT SCAN	0.073816		57.00
58.00	05800	MRI	0.159152		58.00
60.00	06000	LABORATORY	0.222439		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000		62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.247923		63.00
65.00	06500	RESPIRATORY THERAPY	0.090281		65.00
66.00	06600	PHYSICAL THERAPY	0.360727		66.00
69.00	06900	ELECTROCARDIOLOGY	0.197339		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.142922		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.921850		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.605014		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.181523		73.00
75.00	07500	ASC (NON-DISTINCT PART)	1.614984		75.00
76.00	03951	HEMODIALYSIS	1.010071		76.00
76.01	03952	DIABETES CENTER	0.000000		76.01
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000		76.98
76.99	07699	LITHOTRIPSY	0.000000		76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.459861		90.00
90.01	09001	CHEMOTHERAPY	0.387210		90.01
90.02	09002	KEDZIE CLINIC	0.255738		90.02
90.03	09003	LITTLE VILLAGE CLINIC	0.358737		90.03
91.00	09100	EMERGENCY	0.152583		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.695589		92.00
OTHER REIMBURSABLE COST CENTERS					
99.20	09920	OUTPATIENT PHYSICAL THERAPY			99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY			99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY			99.40
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0095

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
1/28/2021 12:08 pm

			Title XIX	Hospital	Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Total Costs
			1.00	2.00	3.00	4.00
						5.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	17,193,629		17,193,629	0
31.00	03100	INTENSIVE CARE UNIT	5,170,721		5,170,721	23,697
40.00	04000	SUBPROVIDER - IPF	8,204,439		8,204,439	130,903
43.00	04300	NURSERY	2,039,897		2,039,897	0
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,565,258		5,565,258	0
51.00	05100	RECOVERY ROOM	547,567		547,567	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,275,100		5,275,100	0
53.00	05300	ANESTHESIOLOGY	892,290		892,290	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,104,327		8,104,327	0
57.00	05700	CT SCAN	1,416,617		1,416,617	0
58.00	05800	MRI	353,774		353,774	0
60.00	06000	LABORATORY	6,046,193		6,046,193	0
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	781,482		781,482	0
65.00	06500	RESPIRATORY THERAPY	1,389,400	0	1,389,400	0
66.00	06600	PHYSICAL THERAPY	1,914,577	0	1,914,577	2,619
69.00	06900	ELECTROCARDIOLOGY	938,142		938,142	0
70.00	07000	ELECTROENCEPHALOGRAPHY	158,022		158,022	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,030,217		6,030,217	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,189,531		1,189,531	0
73.00	07300	DRUGS CHARGED TO PATIENTS	6,561,545		6,561,545	0
75.00	07500	ASC (NON-DISTINCT PART)	788,739		788,739	0
76.00	03951	HEMODIALYSIS	594,168		594,168	0
76.01	03952	DIABETES CENTER	0		0	0
76.97	07697	CARDIAC REHABILITATION	0		0	0
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0
76.99	07699	LITHOTRIPSY	0		0	0
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	5,321,255		5,321,255	39,090
90.01	09001	CHEMOTHERAPY	653,270		653,270	0
90.02	09002	KEDZIE CLINIC	938,323		938,323	0
90.03	09003	LITTLE VILLAGE CLINIC	2,063,615		2,063,615	0
91.00	09100	EMERGENCY	6,981,563		6,981,563	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,903,471		1,903,471	0
OTHER REIMBURSABLE COST CENTERS						
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0		0	0
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0		0	0
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0		0	0
200.00		Subtotal (see instructions)	99,017,132	0	99,017,132	196,309
201.00		Less Observation Beds	1,903,471		1,903,471	0
202.00		Total (see instructions)	97,113,661	0	97,113,661	196,309

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0095

Period:
From 07/01/2019
To 06/30/2020Worksheet C
Part I
Date/Time Prepared:
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			Title XIX		Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00	9.00	10.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	28,135,941		28,135,941		30.00
31.00	03100	INTENSIVE CARE UNIT	12,114,668		12,114,668		31.00
40.00	04000	SUBPROVIDER - IPF	14,033,164		14,033,164		40.00
43.00	04300	NURSERY	4,522,020		4,522,020		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	3,151,277	11,646,041	14,797,318	0.376099	50.00
51.00	05100	RECOVERY ROOM	242,200	574,176	816,376	0.670729	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,683,907	1,766,988	9,450,895	0.558159	52.00
53.00	05300	ANESTHESIOLOGY	2,235,773	3,240,107	5,475,880	0.162949	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,752,019	15,724,553	21,476,572	0.377357	54.00
57.00	05700	CT SCAN	5,002,790	14,188,441	19,191,231	0.073816	57.00
58.00	05800	MRI	635,398	1,587,473	2,222,871	0.159152	58.00
60.00	06000	LABORATORY	11,259,700	15,921,691	27,181,391	0.222439	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,323,927	828,195	3,152,122	0.247923	63.00
65.00	06500	RESPIRATORY THERAPY	14,656,540	733,189	15,389,729	0.090281	65.00
66.00	06600	PHYSICAL THERAPY	803,643	4,511,166	5,314,809	0.360234	66.00
69.00	06900	ELECTROCARDIOLOGY	1,934,262	2,819,692	4,753,954	0.197339	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	94,436	1,011,218	1,105,654	0.142922	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,904,440	2,636,991	6,541,431	0.921850	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,011,606	954,517	1,966,123	0.605014	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	19,311,677	16,835,412	36,147,089	0.181523	73.00
75.00	07500	ASC (NON-DISTINCT PART)	1,468	486,920	488,388	1.614984	75.00
76.00	03951	HEMODIALYSIS	548,338	39,906	588,244	1.010071	76.00
76.01	03952	DIABETES CENTER	0	0	0	0.000000	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	11,656,446	11,656,446	0.456507	90.00
90.01	09001	CHEMOTHERAPY	0	1,687,122	1,687,122	0.387210	90.01
90.02	09002	KEDZIE CLINIC	0	3,669,078	3,669,078	0.255738	90.02
90.03	09003	LITTLE VILLAGE CLINIC	0	5,752,440	5,752,440	0.358737	90.03
91.00	09100	EMERGENCY	7,767,139	37,988,639	45,755,778	0.152583	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	34,490	2,701,998	2,736,488	0.695589	92.00
OTHER REIMBURSABLE COST CENTERS							
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0		99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0		99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0		99.40
200.00		Subtotal (see instructions)	147,160,823	158,962,399	306,123,222		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	147,160,823	158,962,399	306,123,222		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0095	Period: From 07/01/2019 To 06/30/2020	Worksheet C Part I Date/Time Prepared: 1/28/2021 12:08 pm
			Title XIX	Hospital	Cost
Cost Center Description			PPS Inpatient Ratio		
			11.00		
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MRI	0.000000		58.00
60.00	06000	LABORATORY	0.000000		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000		62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000		63.00
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000		75.00
76.00	03951	HEMODIALYSIS	0.000000		76.00
76.01	03952	DIABETES CENTER	0.000000		76.01
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000		76.98
76.99	07699	LITHOTRIPSY	0.000000		76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	CHEMOTHERAPY	0.000000		90.01
90.02	09002	KEDZIE CLINIC	0.000000		90.02
90.03	09003	LITTLE VILLAGE CLINIC	0.000000		90.03
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS					
99.20	09920	OUTPATIENT PHYSICAL THERAPY			99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY			99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY			99.40
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS				Provider CCN: 14-0095	Period: From 07/01/2019 To 06/30/2020	Worksheet D Part I Date/Time Prepared: 1/28/2021 12:08 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	790,267	0	790,267	16,277	48.55	30.00
31.00	INTENSIVE CARE UNIT	129,425		129,425	3,501	36.97	31.00
40.00	SUBPROVIDER - IPF	271,107	0	271,107	8,758	30.96	40.00
43.00	NURSERY	37,596		37,596	2,937	12.80	43.00
200.00	Total (lines 30 through 199)	1,228,395		1,228,395	31,473		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	1,584	76,903				
31.00	INTENSIVE CARE UNIT	529	19,557				
40.00	SUBPROVIDER - IPF	1,214	37,585				
43.00	NURSERY	0	0				
200.00	Total (lines 30 through 199)	3,327	134,045				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS				Provider CCN: 14-0095	Period: From 07/01/2019 To 06/30/2020	Worksheet D Part II Date/Time Prepared: 1/28/2021 12:08 pm			
				Title XVIII		Hospital			
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)	PPS
				1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	113,582	14,797,318	0.007676	435,959	3,346	50.00	
51.00	05100	RECOVERY ROOM	2,567	816,376	0.003144	29,780	94	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	91,566	9,450,895	0.009689	14,918	145	52.00	
53.00	05300	ANESTHESIOLOGY	17,407	5,475,880	0.003179	183,054	582	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	196,915	21,476,572	0.009169	1,079,427	9,897	54.00	
57.00	05700	CT SCAN	8,499	19,191,231	0.000443	802,189	355	57.00	
58.00	05800	MRI	1,791	2,222,871	0.000806	78,310	63	58.00	
60.00	06000	LABORATORY	135,479	27,181,391	0.004984	1,243,984	6,200	60.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30	
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,926	3,152,122	0.000928	274,841	255	63.00	
65.00	06500	RESPIRATORY THERAPY	28,883	15,389,729	0.001877	1,841,002	3,456	65.00	
66.00	06600	PHYSICAL THERAPY	35,344	5,314,809	0.006650	174,950	1,163	66.00	
69.00	06900	ELECTROCARDIOLOGY	19,728	4,753,954	0.004150	397,731	1,651	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	10,451	1,105,654	0.009452	16,379	155	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	87,596	6,541,431	0.013391	544,627	7,293	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	15,966	1,966,123	0.008121	176,917	1,437	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	73,269	36,147,089	0.002027	2,183,605	4,426	73.00	
75.00	07500	ASC (NON-DISTINCT PART)	4,351	488,388	0.008909	497	4	75.00	
76.00	03951	HEMODIALYSIS	1,871	588,244	0.003181	135,976	433	76.00	
76.01	03952	DIABETES CENTER	0	0	0.000000	0	0	76.01	
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97	
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98	
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0	76.99	
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	120,063	11,656,446	0.010300	0	0	90.00	
90.01	09001	CHEMOTHERAPY	3,442	1,687,122	0.002040	0	0	90.01	
90.02	09002	KEDZIE CLINIC	3,552	3,669,078	0.000968	0	0	90.02	
90.03	09003	LITTLE VILLAGE CLINIC	7,312	5,752,440	0.001271	0	0	90.03	
91.00	09100	EMERGENCY	104,413	45,755,778	0.002282	936,204	2,136	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	87,489	2,736,488	0.031971	2,516	80	92.00	
200.00		Total (lines 50 through 199)	1,174,462	247,317,429		10,552,866	43,171	200.00	

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0095		Period: From 07/01/2019 To 06/30/2020		Worksheet D Part III Date/Time Prepared: 1/28/2021 12:08 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	
43.00	04300	NURSERY		0	0	0	0	0	0	43.00	
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	16,277	0.00	1,584		30.00	
31.00	03100	INTENSIVE CARE UNIT			0	3,501	0.00	529		31.00	
40.00	04000	SUBPROVIDER - IPF		0	0	8,758	0.00	1,214		40.00	
43.00	04300	NURSERY			0	2,937	0.00	0		43.00	
200.00		Total (lines 30 through 199)			0	31,473		3,327		200.00	
Cost Center Description					Inpatient Program Pass-Through Cost (col. 7 x col. 8)						
					9.00						
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS		0						30.00	
31.00	03100	INTENSIVE CARE UNIT		0						31.00	
40.00	04000	SUBPROVIDER - IPF		0						40.00	
43.00	04300	NURSERY		0						43.00	
200.00		Total (lines 30 through 199)		0						200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
THROUGH COSTS

Provider CCN: 14-0095

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

Worksheet D
Part IV
Date/Time Prepared:
1/28/2021 12:08 pm

Cost Center Description		Title XVIII		Hospital		PPS	
		Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
		1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
60.00	06000	LABORATORY	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	0	75.00
76.00	03951	HEMODIALYSIS	0	0	0	0	76.00
76.01	03952	DIABETES CENTER	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09001	CHEMOTHERAPY	0	0	0	0	90.01
90.02	09002	KEDZIE CLINIC	0	0	0	0	90.02
90.03	09003	LITTLE VILLAGE CLINIC	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 14-0095		Period: From 07/01/2019 To 06/30/2020		Worksheet D Part IV Date/Time Prepared: 1/28/2021 12:08 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	14,797,318	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	816,376	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	9,450,895	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	5,475,880	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	21,476,572	0.000000	54.00
57.00	05700	CT SCAN	0	0	0	19,191,231	0.000000	57.00
58.00	05800	MRI	0	0	0	2,222,871	0.000000	58.00
60.00	06000	LABORATORY	0	0	0	27,181,391	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	3,152,122	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	15,389,729	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	5,314,809	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	4,753,954	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	1,105,654	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	6,541,431	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	1,966,123	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	36,147,089	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0	0	488,388	0.000000	75.00
76.00	03951	HEMODIALYSIS	0	0	0	588,244	0.000000	76.00
76.01	03952	DIABETES CENTER	0	0	0	0	0.000000	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	11,656,446	0.000000	90.00
90.01	09001	CHEMOTHERAPY	0	0	0	1,687,122	0.000000	90.01
90.02	09002	KEDZIE CLINIC	0	0	0	3,669,078	0.000000	90.02
90.03	09003	LITTLE VILLAGE CLINIC	0	0	0	5,752,440	0.000000	90.03
91.00	09100	EMERGENCY	0	0	0	45,755,778	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	2,736,488	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	247,317,429		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0095

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part IV
Date/Time Prepared:
1/28/2021 12:08 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	435,959	0	734,530	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	29,780	0	48,394	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	14,918	0	256	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	183,054	0	296,325	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	1,079,427	0	1,757,064	0	54.00
57.00	05700	CT SCAN	0.000000	802,189	0	1,266,068	0	57.00
58.00	05800	MRI	0.000000	78,310	0	209,170	0	58.00
60.00	06000	LABORATORY	0.000000	1,243,984	0	975,051	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	274,841	0	88,559	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	1,841,002	0	98,937	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	174,950	0	19,245	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	397,731	0	413,916	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	16,379	0	147,220	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	544,627	0	192,146	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	176,917	0	135,927	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	2,183,605	0	4,987,378	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	0.000000	497	0	60,148	0	75.00
76.00	03951	HEMODIALYSIS	0.000000	135,976	0	17,736	0	76.00
76.01	03952	DIABETES CENTER	0.000000	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0.000000	0	0	1,697,532	0	90.00
90.01	09001	CHEMOTHERAPY	0.000000	0	0	612,778	0	90.01
90.02	09002	KEDZIE CLINIC	0.000000	0	0	309	0	90.02
90.03	09003	LITTLE VILLAGE CLINIC	0.000000	0	0	152,485	0	90.03
91.00	09100	EMERGENCY	0.000000	936,204	0	1,679,363	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	2,516	0	356,742	0	92.00
200.00		Total (lines 50 through 199)		10,552,866	0	15,947,279	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0095

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part V
Date/Time Prepared:
1/28/2021 12:08 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	0.376099	734,530	0	0	276,256	50.00
51.00	05100	RECOVERY ROOM	0.670729	48,394	0	0	32,459	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.558159	256	0	0	143	52.00
53.00	05300	ANESTHESIOLOGY	0.162949	296,325	0	0	48,286	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.377357	1,757,064	0	164	663,040	54.00
57.00	05700	CT SCAN	0.073816	1,266,068	0	632	93,456	57.00
58.00	05800	MRI	0.159152	209,170	0	53	33,290	58.00
60.00	06000	LABORATORY	0.222439	975,051	0	0	216,889	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.247923	88,559	0	0	21,956	63.00
65.00	06500	RESPIRATORY THERAPY	0.090281	98,937	0	0	8,932	65.00
66.00	06600	PHYSICAL THERAPY	0.360234	19,245	0	0	6,933	66.00
69.00	06900	ELECTROCARDIOLOGY	0.197339	413,916	0	14	81,682	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.142922	147,220	0	0	21,041	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.921850	192,146	0	0	177,130	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.605014	135,927	0	0	82,238	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.181523	4,987,378	0	46,359	905,324	73.00
75.00	07500	ASC (NON-DISTINCT PART)	1.614984	60,148	0	0	97,138	75.00
76.00	03951	HEMODIALYSIS	1.010071	17,736	0	4,720	17,915	76.00
76.01	03952	DIABETES CENTER	0.000000	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.456507	1,697,532	0	420	774,935	90.00
90.01	09001	CHEMOTHERAPY	0.387210	612,778	0	111	237,274	90.01
90.02	09002	KEDZIE CLINIC	0.255738	309	0	0	79	90.02
90.03	09003	LITTLE VILLAGE CLINIC	0.358737	152,485	0	5	54,702	90.03
91.00	09100	EMERGENCY	0.152583	1,679,363	0	260	256,242	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.695589	356,742	0	0	248,146	92.00
200.00		Subtotal (see instructions)		15,947,279	0	52,738	4,355,486	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		15,947,279	0	52,738	4,355,486	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0095

Period:
From 07/01/2019
To 06/30/2020Worksheet D
Part V
Date/Time Prepared:
1/28/2021 12:08 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	62		54.00
57.00	05700	CT SCAN	0	47		57.00
58.00	05800	MRI	0	8		58.00
60.00	06000	LABORATORY	0	0		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	3		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	8,415		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0		75.00
76.00	03951	HEMODIALYSIS	0	4,768		76.00
76.01	03952	DIABETES CENTER	0	0		76.01
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0		76.99
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0	192		90.00
90.01	09001	CHEMOTHERAPY	0	43		90.01
90.02	09002	KEDZIE CLINIC	0	0		90.02
90.03	09003	LITTLE VILLAGE CLINIC	0	2		90.03
91.00	09100	EMERGENCY	0	40		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	13,580		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	13,580		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0095

Period:

Worksheet D

Component CCN: 14-S095

From 07/01/2019

Part II

To 06/30/2020

Date/Time Prepared:

1/28/2021 12:08 pm

Title XVIII

Subprovider -
IPF

PPS

Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	113,582	14,797,318	0.007676	0	0	50.00
51.00	05100	RECOVERY ROOM	2,567	816,376	0.003144	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	91,566	9,450,895	0.009689	0	0	52.00
53.00	05300	ANESTHESIOLOGY	17,407	5,475,880	0.003179	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	196,915	21,476,572	0.009169	11,774	108	54.00
57.00	05700	CT SCAN	8,499	19,191,231	0.000443	12,489	6	57.00
58.00	05800	MRI	1,791	2,222,871	0.000806	0	0	58.00
60.00	06000	LABORATORY	135,479	27,181,391	0.004984	142,280	709	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,926	3,152,122	0.000928	4,986	5	63.00
65.00	06500	RESPIRATORY THERAPY	28,883	15,389,729	0.001877	24,718	46	65.00
66.00	06600	PHYSICAL THERAPY	35,344	5,314,809	0.006650	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	19,728	4,753,954	0.004150	14,766	61	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	10,451	1,105,654	0.009452	645	6	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	87,596	6,541,431	0.013391	3,592	48	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	15,966	1,966,123	0.008121	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73,269	36,147,089	0.002027	198,174	402	73.00
75.00	07500	ASC (NON-DISTINCT PART)	4,351	488,388	0.008909	0	0	75.00
76.00	03951	HEMODIALYSIS	1,871	588,244	0.003181	0	0	76.00
76.01	03952	DIABETES CENTER	0	0	0.000000	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	120,063	11,656,446	0.010300	0	0	90.00
90.01	09001	CHEMOTHERAPY	3,442	1,687,122	0.002040	0	0	90.01
90.02	09002	KEDZIE CLINIC	3,552	3,669,078	0.000968	0	0	90.02
90.03	09003	LITTLE VILLAGE CLINIC	7,312	5,752,440	0.001271	0	0	90.03
91.00	09100	EMERGENCY	104,413	45,755,778	0.002282	139,794	319	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	2,736,488	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	1,086,973	247,317,429		553,218	1,710	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0095 Component CCN: 14-S095		Period: From 07/01/2019 To 06/30/2020		Worksheet D Part IV Date/Time Prepared: 1/28/2021 12:08 pm	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM		0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0	54.00
57.00	05700	CT SCAN		0	0	0	0	0	57.00
58.00	05800	MRI		0	0	0	0	0	58.00
60.00	06000	LABORATORY		0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS		0	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.		0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)		0	0	0	0	0	75.00
76.00	03951	HEMODIALYSIS		0	0	0	0	0	76.00
76.01	03952	DIABETES CENTER		0	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION		0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY		0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	0	0	90.00
90.01	09001	CHEMOTHERAPY		0	0	0	0	0	90.01
90.02	09002	KEDZIE CLINIC		0	0	0	0	0	90.02
90.03	09003	LITTLE VILLAGE CLINIC		0	0	0	0	0	90.03
91.00	09100	EMERGENCY		0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0095 Component CCN: 14-S095		Period: From 07/01/2019 To 06/30/2020		Worksheet D Part IV Date/Time Prepared: 1/28/2021 12:08 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	14,797,318	0.000000	50.00
51.00	05100	RECOVERY ROOM		0	0	0	816,376	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	9,450,895	0.000000	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	5,475,880	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	21,476,572	0.000000	54.00
57.00	05700	CT SCAN		0	0	0	19,191,231	0.000000	57.00
58.00	05800	MRI		0	0	0	2,222,871	0.000000	58.00
60.00	06000	LABORATORY		0	0	0	27,181,391	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS		0	0	0	0	0.000000	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.		0	0	0	3,152,122	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY		0	0	0	15,389,729	0.000000	65.00
66.00	06600	PHYSICAL THERAPY		0	0	0	5,314,809	0.000000	66.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	4,753,954	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	1,105,654	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	6,541,431	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	1,966,123	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	36,147,089	0.000000	73.00
75.00	07500	ASC (NON-DISTINCT PART)		0	0	0	488,388	0.000000	75.00
76.00	03951	HEMODIALYSIS		0	0	0	588,244	0.000000	76.00
76.01	03952	DIABETES CENTER		0	0	0	0	0.000000	76.01
76.97	07697	CARDIAC REHABILITATION		0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY		0	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0	0	0	11,656,446	0.000000	90.00
90.01	09001	CHEMOTHERAPY		0	0	0	1,687,122	0.000000	90.01
90.02	09002	KEDZIE CLINIC		0	0	0	3,669,078	0.000000	90.02
90.03	09003	LITTLE VILLAGE CLINIC		0	0	0	5,752,440	0.000000	90.03
91.00	09100	EMERGENCY		0	0	0	45,755,778	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		0	0	0	2,736,488	0.000000	92.00
200.00		Total (lines 50 through 199)		0	0	0	247,317,429		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0095 Component CCN: 14-S095		Period: From 07/01/2019 To 06/30/2020		Worksheet D Part IV Date/Time Prepared: 1/28/2021 12:08 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	50.00
51.00	05100	RECOVERY ROOM		0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0.000000	11,774	0	0	0	54.00
57.00	05700	CT SCAN		0.000000	12,489	0	0	0	57.00
58.00	05800	MRI		0.000000	0	0	0	0	58.00
60.00	06000	LABORATORY		0.000000	142,280	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS		0.000000	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.		0.000000	4,986	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY		0.000000	24,718	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY		0.000000	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY		0.000000	14,766	0	196	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		0.000000	645	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0.000000	3,592	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0.000000	198,174	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)		0.000000	0	0	0	0	75.00
76.00	03951	HEMODIALYSIS		0.000000	0	0	0	0	76.00
76.01	03952	DIABETES CENTER		0.000000	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION		0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY		0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY		0.000000	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC		0.000000	0	0	0	0	90.00
90.01	09001	CHEMOTHERAPY		0.000000	0	0	0	0	90.01
90.02	09002	KEDZIE CLINIC		0.000000	0	0	0	0	90.02
90.03	09003	LITTLE VILLAGE CLINIC		0.000000	0	0	0	0	90.03
91.00	09100	EMERGENCY		0.000000	139,794	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)			553,218	0	196	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 14-0095 Component CCN: 14-S095		Period: From 07/01/2019 To 06/30/2020		Worksheet D Part V Date/Time Prepared: 1/28/2021 12:08 pm	
			Title XVIII		Subprovider - IPF		PPS	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	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	0.376099	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.670729	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.558159	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.162949	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.377357	0	0	0	0	54.00
57.00	05700	CT SCAN	0.073816	0	0	0	0	57.00
58.00	05800	MRI	0.159152	0	0	0	0	58.00
60.00	06000	LABORATORY	0.222439	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.247923	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.090281	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.360234	0	0	0	0	66.00
69.00	06900	ELECTROCARDIOLOGY	0.197339	196	0	0	39	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.142922	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.921850	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.605014	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.181523	0	0	0	0	73.00
75.00	07500	ASC (NON-DISTINCT PART)	1.614984	0	0	0	0	75.00
76.00	03951	HEMODIALYSIS	1.010071	0	0	0	0	76.00
76.01	03952	DIABETES CENTER	0.000000	0	0	0	0	76.01
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.456507	0	0	0	0	90.00
90.01	09001	CHEMOTHERAPY	0.387210	0	0	0	0	90.01
90.02	09002	KEDZIE CLINIC	0.255738	0	0	0	0	90.02
90.03	09003	LITTLE VILLAGE CLINIC	0.358737	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.152583	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.695589	0	0	0	0	92.00
200.00		Subtotal (see instructions)		196	0	0	39	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		196	0	0	39	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0095

Period:

Worksheet D

Component CCN: 14-S095

From 07/01/2019
To 06/30/2020Part V
Date/Time Prepared:
1/28/2021 12:08 pm

Title XVIII

Subprovider -
IPF

PPS

Cost Center Description			Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0		
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
60.00	06000	LABORATORY	0	0		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
75.00	07500	ASC (NON-DISTINCT PART)	0	0		75.00
76.00	03951	HEMODIALYSIS	0	0		76.00
76.01	03952	DIABETES CENTER	0	0		76.01
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0		76.99
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0		90.00
90.01	09001	CHEMOTHERAPY	0	0		90.01
90.02	09002	KEDZIE CLINIC	0	0		90.02
90.03	09003	LITTLE VILLAGE CLINIC	0	0		90.03
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0095	Period: From 07/01/2019 To 06/30/2020	Worksheet D-1 Date/Time Prepared: 1/28/2021 12:08 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)		16,277	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		16,277	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)		14,475	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		1,584	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)		17,193,629	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)		17,193,629	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)		17,193,629	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,056.31	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,673,195	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,673,195	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0095

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

Worksheet D-1

Date/Time Prepared:
1/28/2021 12:08 pm

Cost Center Description		Title XVIII		Hospital		PPS
		Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
		1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	5,194,418	3,501	1,483.70	529	784,877
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)					2,644,318
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					5,102,390
PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					96,460
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					43,171
52.00	Total Program excludable cost (sum of lines 50 and 51)					139,631
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					4,962,759
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)					1,802
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,056.31
89.00	Observation bed cost (line 87 x line 88) (see instructions)					1,903,471

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0095

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

Worksheet D-1

Date/Time Prepared:
1/28/2021 12:08 pm

Cost Center Description		Title XVIII		Hospital	PPS	
		Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00
COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	790,267	17,193,629	0.045963	1,903,471	87,489
91.00	Nursing School cost	0	17,193,629	0.000000	1,903,471	0
92.00	Allied health cost	0	17,193,629	0.000000	1,903,471	0
93.00	All other Medical Education	0	17,193,629	0.000000	1,903,471	0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0095 Component CCN: 14-S095	Period: From 07/01/2019 To 06/30/2020	Worksheet D-1 Date/Time Prepared: 1/28/2021 12:08 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)		8,758	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		8,758	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		8,758	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		1,214	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)		8,335,342	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)		8,335,342	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)		8,335,342	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)		951.74	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,155,412	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,155,412	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0095 Component CCN: 14-S095	Period: From 07/01/2019 To 06/30/2020	Worksheet D-1 Date/Time Prepared: 1/28/2021 12:08 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)					104,102
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,259,514
PASS THROUGH COST ADJUSTMENTS					
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					37,585
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					1,710
52.00 Total Program excludable cost (sum of lines 50 and 51)					39,295
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					1,220,219
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: 14-0095 Component CCN: 14-S095		Period: From 07/01/2019 To 06/30/2020		Worksheet D-1 Date/Time Prepared: 1/28/2021 12:08 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	271,107	8,335,342	0.032525	0	0	90.00
91.00	Nursing School cost	0	8,335,342	0.000000	0	0	91.00
92.00	Allied health cost	0	8,335,342	0.000000	0	0	92.00
93.00	All other Medical Education	0	8,335,342	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0095

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

Worksheet D-1

Date/Time Prepared:
1/28/2021 12:08 pm

Title XIX		Hospital	Cost
Cost Center Description			1.00
PART I - ALL PROVIDER COMPONENTS			
INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	16,277	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	16,277	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)	14,475	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	1,432	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	2,937	15.00
16.00	Nursery days (title V or XIX only)	2,528	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)	17,193,629	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)	17,193,629	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)	17,193,629	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY			
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS			
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,056.31	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,512,636	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	1,512,636	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0095

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

Worksheet D-1

Date/Time Prepared:
1/28/2021 12:08 pm

			Title XIX		Hospital	Cost		
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
		1.00	2.00	3.00	4.00	5.00		
42.00	NURSERY (title V & XIX only)	2,039,897	2,937	694.55	2,528	1,755,822	42.00	
	Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	5,170,721	3,501	1,476.93	489	722,219	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)						2,373,103	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						6,363,780	49.00
	PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						0	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)						0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges						0	54.00
55.00	Target amount per discharge						0.00	55.00
56.00	Target amount (line 54 x line 55)						0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0	57.00
58.00	Bonus payment (see instructions)						0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						0	61.00
62.00	Relief payment (see instructions)						0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)						0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)							70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00	Program routine service cost (line 9 x line 71)							72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00	Program capital-related costs (line 9 x line 76)							77.00
78.00	Inpatient routine service cost (line 74 minus line 77)							78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00	Inpatient routine service cost per diem limitation							81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00	Reasonable inpatient routine service costs (see instructions)							83.00
84.00	Program inpatient ancillary services (see instructions)							84.00
85.00	Utilization review - physician compensation (see instructions)							85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)						1,802	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						1,056.31	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)						1,903,471	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0095

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

Worksheet D-1

Date/Time Prepared:
1/28/2021 12:08 pm

Cost Center Description		Title XIX		Hospital		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	790,267	17,193,629	0.045963	1,903,471	87,489	90.00
91.00	Nursing School cost	0	17,193,629	0.000000	1,903,471	0	91.00
92.00	Allied health cost	0	17,193,629	0.000000	1,903,471	0	92.00
93.00	All other Medical Education	0	17,193,629	0.000000	1,903,471	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0095	Period: From 07/01/2019 To 06/30/2020	Worksheet D-3 Date/Time Prepared: 1/28/2021 12:08 pm
			Title XVIII	Hospital	PPS
Cost Center Description			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
			1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		3,248,096	30.00
31.00	03100	INTENSIVE CARE UNIT		1,733,290	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.376099	435,959	50.00
51.00	05100	RECOVERY ROOM	0.670729	29,780	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.558159	14,918	52.00
53.00	05300	ANESTHESIOLOGY	0.162949	183,054	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.377357	1,079,427	54.00
57.00	05700	CT SCAN	0.073816	802,189	57.00
58.00	05800	MRI	0.159152	78,310	58.00
60.00	06000	LABORATORY	0.222439	1,243,984	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.247923	274,841	63.00
65.00	06500	RESPIRATORY THERAPY	0.090281	1,841,002	65.00
66.00	06600	PHYSICAL THERAPY	0.360727	174,950	66.00
69.00	06900	ELECTROCARDIOLOGY	0.197339	397,731	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.142922	16,379	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.921850	544,627	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.605014	176,917	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.181523	2,183,605	73.00
75.00	07500	ASC (NON-DISTINCT PART)	1.614984	497	75.00
76.00	03951	HEMODIALYSIS	1.010071	135,976	76.00
76.01	03952	DIABETES CENTER	0.000000	0	76.01
76.97	07697	CARDIAC REHABILITATION	0.000000	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.459861	0	90.00
90.01	09001	CHEMOTHERAPY	0.387210	0	90.01
90.02	09002	KEDZIE CLINIC	0.255738	0	90.02
90.03	09003	LITTLE VILLAGE CLINIC	0.358737	0	90.03
91.00	09100	EMERGENCY	0.152583	936,204	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.695589	2,516	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		10,552,866	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)		10,552,866	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0095 Component CCN: 14-S095	Period: From 07/01/2019 To 06/30/2020	Worksheet D-3 Date/Time Prepared: 1/28/2021 12:08 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		1,962,861		40.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.376099	0	0	50.00
51.00	05100 RECOVERY ROOM	0.670729	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.558159	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.162949	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.377357	11,774	4,443	54.00
57.00	05700 CT SCAN	0.073816	12,489	922	57.00
58.00	05800 MRI	0.159152	0	0	58.00
60.00	06000 LABORATORY	0.222439	142,280	31,649	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.247923	4,986	1,236	63.00
65.00	06500 RESPIRATORY THERAPY	0.090281	24,718	2,232	65.00
66.00	06600 PHYSICAL THERAPY	0.360727	0	0	66.00
69.00	06900 ELECTROCARDIOLOGY	0.197339	14,766	2,914	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.142922	645	92	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.921850	3,592	3,311	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.605014	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.181523	198,174	35,973	73.00
75.00	07500 ASC (NON-DISTINCT PART)	1.614984	0	0	75.00
76.00	03951 HEMODIALYSIS	1.010071	0	0	76.00
76.01	03952 DIABETES CENTER	0.000000	0	0	76.01
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699 LITHOTRIPSY	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.459861	0	0	90.00
90.01	09001 CHEMOTHERAPY	0.387210	0	0	90.01
90.02	09002 KEDZIE CLINIC	0.255738	0	0	90.02
90.03	09003 LITTLE VILLAGE CLINIC	0.358737	0	0	90.03
91.00	09100 EMERGENCY	0.152583	139,794	21,330	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.695589	0	0	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		553,218	104,102	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)		553,218		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			Provider CCN: 14-0095	Period: From 07/01/2019 To 06/30/2020	Worksheet D-3 Date/Time Prepared: 1/28/2021 12:08 pm
Cost Center Description			Title XIX	Hospital	Cost
			Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)
			1.00	2.00	3.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		3,218,140	30.00
31.00	03100	INTENSIVE CARE UNIT		1,684,961	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
43.00	04300	NURSERY		3,866,424	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.376099	482,448	50.00
51.00	05100	RECOVERY ROOM	0.670729	31,245	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.558159	580,513	52.00
53.00	05300	ANESTHESIOLOGY	0.162949	270,933	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.377357	564,776	54.00
57.00	05700	CT SCAN	0.073816	318,561	57.00
58.00	05800	MRI	0.159152	53,991	58.00
60.00	06000	LABORATORY	0.222439	1,608,565	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	62.30
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.247923	380,953	63.00
65.00	06500	RESPIRATORY THERAPY	0.090281	1,718,477	65.00
66.00	06600	PHYSICAL THERAPY	0.360234	146,765	66.00
69.00	06900	ELECTROCARDIOLOGY	0.197339	138,790	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.142922	4,445	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.921850	368,824	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.605014	39,037	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.181523	2,113,437	73.00
75.00	07500	ASC (NON-DISTINCT PART)	1.614984	0	75.00
76.00	03951	HEMODIALYSIS	1.010071	73,900	76.00
76.01	03952	DIABETES CENTER	0.000000	0	76.01
76.97	07697	CARDIAC REHABILITATION	0.000000	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.456507	0	90.00
90.01	09001	CHEMOTHERAPY	0.387210	0	90.01
90.02	09002	KEDZIE CLINIC	0.255738	0	90.02
90.03	09003	LITTLE VILLAGE CLINIC	0.358737	0	90.03
91.00	09100	EMERGENCY	0.152583	282,140	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.695589	5,833	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		9,183,633	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)		9,183,633	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0095

Period:
From 07/01/2019
To 06/30/2020Worksheet E
Part A
Date/Time Prepared:
1/28/2021 12:08 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)			1,027,318	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)			2,522,286	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)			0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)			0	1.04
2.00	Outlier payments for discharges. (see instructions)				2.00
2.01	Outlier reconciliation amount			0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)			0	2.02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)			0	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)			50,803	2.04
3.00	Managed Care Simulated Payments			0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)			104.03	4.00
Indirect Medical Education Adjustment					
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)			5.59	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)			0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)			2.33	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.			1.17	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).			0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.			0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)			0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)			2.09	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records			3.11	10.00
11.00	FTE count for residents in dental and podiatric programs.			1.63	11.00
12.00	Current year allowable FTE (see instructions)			3.72	12.00
13.00	Total allowable FTE count for the prior year.			3.65	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.			3.07	14.00
15.00	Sum of lines 12 through 14 divided by 3.			3.48	15.00
16.00	Adjustment for residents in initial years of the program			0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure			0.00	17.00
18.00	Adjusted rolling average FTE count			3.48	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).			0.033452	19.00
20.00	Prior year resident to bed ratio (see instructions)			0.035344	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)			0.033452	21.00
22.00	IME payment adjustment (see instructions)			64,290	22.00
22.01	IME payment adjustment - Managed Care (see instructions)			0	22.01
Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA					
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).			0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)			1.02	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)			64,290	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			0	29.01
Disproportionate Share Adjustment					
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)			21.59	30.00
31.00	Percentage of Medicaid patient days (see instructions)			59.55	31.00
32.00	Sum of lines 30 and 31			81.14	32.00
33.00	Allowable disproportionate share percentage (see instructions)			56.15	33.00
34.00	Disproportionate share adjustment (see instructions)			498,276	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0095	Period: From 07/01/2019 To 06/30/2020	Worksheet E Part A Date/Time Prepared: 1/28/2021 12:08 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)	2,260,224	1,837,177		35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	569,701	1,375,373		35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,945,074			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)	6,108,047			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)		6,108,047		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		337,975		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).		38,092		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)		6,484,114		59.00
60.00	Primary payer payments		0		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		6,484,114		61.00
62.00	Deductibles billed to program beneficiaries		395,648		62.00
63.00	Coinsurance billed to program beneficiaries		16,126		63.00
64.00	Allowable bad debts (see instructions)		381,855		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		248,206		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		272,763		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		6,320,546		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)		0		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0		70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0		70.91
70.92	Bundled Model 1 discount amount (see instructions)		0		70.92
70.93	HVBP payment adjustment amount (see instructions)		24,826		70.93
70.94	HRR adjustment amount (see instructions)		-18,365		70.94
70.95	Recovery of accelerated depreciation		0		70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0095	Period: From 07/01/2019 To 06/30/2020	Worksheet E Part A Date/Time Prepared: 1/28/2021 12:08 pm
		Title XVIII	Hospital	PPS
		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		6,327,007	71.00
71.01	Sequestration adjustment (see instructions)		105,661	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs		0	71.03
72.00	Interim payments		5,478,067	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)		743,279	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		141,255	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	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	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: 14-0095

Period:
From 07/01/2019
To 06/30/2020Worksheet E
Part A Exhibit 4
Date/Time Prepared:
1/28/2021 12:08 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	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	1,027,318	0	1,027,318		1,027,318	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,522,286	0		2,522,286	2,522,286	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	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	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	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	0	0	0		0	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	50,803	0		50,803	50,803	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	0	4.00
Indirect Medical Education Adjustment								
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.033452	0.033452	0.033452	0.033452		5.00
6.00	IME payment adjustment (see instructions)	22.00	64,290	0	18,607	45,683	64,290	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA								
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	64,290	0	18,607	45,683	64,290	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
Disproportionate Share Adjustment								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.5615	0.5615	0.5615	0.5615		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	498,276	0	144,210	354,066	498,276	11.00
11.01	Uncompensated care payments	36.00	1,945,074	0	569,701	1,375,373	1,945,074	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	0	12.00
13.00	Subtotal (see instructions)	47.00	6,108,047	0	1,759,836	4,348,211	6,108,047	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	6,108,047	0	1,759,836	4,348,211	6,108,047	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	337,975	0	100,142	237,833	337,975	16.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0095

Period:
From 07/01/2019
To 06/30/2020Worksheet E
Part A Exhibit 4
Date/Time Prepared:
1/28/2021 12:08 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	1,859,978	4,586,044	6,446,022
		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	281,074	0	83,577	197,497	281,074
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	1,192	0	0	1,192	1,192
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	0.0196	0.0196	0.0196	0.0196	
23.00	Indirect medical education adjustment (see instructions)	6.00	5,509	0	1,638	3,871	5,509
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.1786	0.1786	0.1786	0.1786	
25.00	Disproportionate share adjustment (see instructions)	11.00	50,200	0	14,927	35,273	50,200
26.00	Total prospective capital payments (see instructions)	12.00	337,975	0	100,142	237,833	337,975
		W/S E, Part A line	(Amounts to E, Part A)				
		0	1.00	2.00	3.00	4.00	5.00
27.00	Low volume adjustment factor				0.000000	0.000000	
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y				

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0095

Period:
From 07/01/2019
To 06/30/2020Worksheet E
Part A Exhibit 5
Date/Time Prepared:
1/28/2021 12:08 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	1,027,318	1,027,318		1,027,318	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	2,522,286		2,522,286	2,522,286	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00					2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
2.02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2.03	0	0		0	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	50,803		50,803	50,803	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	0	0	0	0	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.033452	0.033452	0.033452		5.00
6.00	IME payment adjustment (see instructions)	22.00	64,290	18,607	45,683	64,290	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	64,290	18,607	45,683	64,290	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.5615	0.5615	0.5615		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	498,276	144,210	354,066	498,276	11.00
11.01	Uncompensated care payments	36.00	1,945,074	569,701	1,375,373	1,945,074	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	6,108,047	1,759,836	4,348,211	6,108,047	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	6,108,047	1,759,836	4,348,211	6,108,047	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	337,975	100,142	237,833	337,975	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			1,859,978	4,586,044	6,446,022	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0095

Period:
From 07/01/2019
To 06/30/2020Worksheet E
Part A Exhibit 5
Date/Time Prepared:
1/28/2021 12:08 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	281,074	83,577	197,497	281,074	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	1,192	0	1,192	1,192	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	0.0196	0.0196	0.0196		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	5,509	1,638	3,871	5,509	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.1786	0.1786	0.1786		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	50,200	14,927	35,273	50,200	25.00
26.00	Total prospective capital payments (see instructions)	12.00	337,975	100,142	237,833	337,975	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	24,826	1,953	22,873	24,826	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	-18,365	-2,979	-15,386	-18,365	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

Health Financial Systems		SAINT ANTHONY HOSPITAL		In Lieu of Form CMS-2552-10	
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0095	Period: From 07/01/2019 To 06/30/2020	Worksheet E Part B Date/Time Prepared: 1/28/2021 12:08 pm	
		Title XVIII	Hospital	PPS	
				1.00	
PART B - MEDICAL AND OTHER HEALTH SERVICES					
1.00	Medical and other services (see instructions)		13,580	1.00	
2.00	Medical and other services reimbursed under OPPS (see instructions)		4,355,486	2.00	
3.00	OPPS payments		3,180,381	3.00	
4.00	Outlier payment (see instructions)		9,207	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)		13,580	11.00	
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable charges					
12.00	Ancillary service charges		52,738	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)		52,738	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)		52,738	18.00	
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		39,158	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)		13,580	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)		3,189,588	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)		658,544	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)		2,544,624	27.00	
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		26,159	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)		2,570,783	30.00	
31.00	Primary payer payments		77	31.00	
32.00	Subtotal (line 30 minus line 31)		2,570,706	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)		334,891	34.00	
35.00	Adjusted reimbursable bad debts (see instructions)		217,679	35.00	
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		234,496	36.00	
37.00	Subtotal (see instructions)		2,788,385	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)		2,788,385	40.00	
40.01	Sequestration adjustment (see instructions)		46,566	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		2,720,882	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)		20,937	43.00	
43.01	Balance due provider/program-PARHM (see instructions)		0	43.01	
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00	
TO BE COMPLETED BY CONTRACTOR					
90.00	Original outlier amount (see instructions)		0	90.00	
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00	
92.00	The rate used to calculate the Time Value of Money		0.00	92.00	
93.00	Time Value of Money (see instructions)		0	93.00	
94.00	Total (sum of lines 91 and 93)		0	94.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0095 Component CCN: 14-S095	Period: From 07/01/2019 To 06/30/2020	Worksheet E Part B Date/Time Prepared: 1/28/2021 12:08 pm
		Title XVIII	Subprovider - IPF	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		39	2.00
3.00	OPPS payments		56	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		0	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		0	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		56	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)		11	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)		45	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		45	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		45	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		45	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50	
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		45	40.00
40.01	Sequestration adjustment (see instructions)		1	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03	
41.00	Interim payments		44	41.00
41.01	Interim payments-PARHM		41.01	
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		42.01	
43.00	Balance due provider/program (see instructions)		0	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01	
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0095

Period:
From 07/01/2019
To 06/30/2020Worksheet E-1
Part I
Date/Time Prepared:
1/28/2021 12:08 pm

		Title XVIII		Hospital		PPS
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		5,498,505		2,759,084	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM	02/19/2020	20,438	02/19/2020	38,202	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)		-20,438		-38,202	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		5,478,067		2,720,882	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		743,279		20,937	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		6,221,346		2,741,819	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN: 14-0095 Component CCN: 14-S095		Period: From 07/01/2019 To 06/30/2020		Worksheet E-1 Part I Date/Time Prepared: 1/28/2021 12:08 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		952,741		44	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		952,741		44	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		316		0	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		953,057		44	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: 14-0095	Period: From 07/01/2019 To 06/30/2020	Worksheet E-1 Part II Date/Time Prepared: 1/28/2021 12:08 pm
		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14			1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168			7.00
8.00	Calculation of the HIT incentive payment (see instructions)			8.00
9.00	Sequestration adjustment amount (see instructions)			9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			30.00
31.00	Other Adjustment (specify)			31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)			32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0095 Component CCN: 14-S095	Period: From 07/01/2019 To 06/30/2020	Worksheet E-3 Part II Date/Time Prepared: 1/28/2021 12:08 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)		1,130,316	1.00
2.00	Net IPF PPS Outlier Payments		0	2.00
3.00	Net IPF PPS ECT Payments		0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)		0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)		0.00	4.01
5.00	New Teaching program adjustment. (see instructions)		0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)		0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)		0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)		0.00	8.00
9.00	Average Daily Census (see instructions)		23.928962	9.00
10.00	Teaching Adjustment Factor $\{((1 + (\text{line 8/line 9})) \text{ raised to the power of } .5150 - 1)\}$.		0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).		0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)		1,130,316	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)		0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)		0	14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)		0	15.00
16.00	Subtotal (see instructions)		1,130,316	16.00
17.00	Primary payer payments		0	17.00
18.00	Subtotal (line 16 less line 17).		1,130,316	18.00
19.00	Deductibles		98,516	19.00
20.00	Subtotal (line 18 minus line 19)		1,031,800	20.00
21.00	Coinsurance		62,557	21.00
22.00	Subtotal (line 20 minus line 21)		969,243	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		0	23.00
24.00	Adjusted reimbursable bad debts (see instructions)		0	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	25.00
26.00	Subtotal (sum of lines 22 and 24)		969,243	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)		969,243	31.00
31.01	Sequestration adjustment (see instructions)		16,186	31.01
31.02	Demonstration payment adjustment amount after sequestration		0	31.02
32.00	Interim payments		952,741	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)		316	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	35.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2		0	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)		0	51.00
52.00	The rate used to calculate the Time Value of Money		0.00	52.00
53.00	Time Value of Money (see instructions)		0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0095

Period:
From 07/01/2019
To 06/30/2020Worksheet E-3
Part VII
Date/Time Prepared:
1/28/2021 12:08 pm

		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		6,363,780		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		6,363,780	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		6,363,780	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		8,769,525		8.00
9.00	Ancillary service charges		9,183,633	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		17,953,158	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		17,953,158	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		11,589,378	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		6,363,780	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		6,363,780	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		6,363,780	0	31.00
32.00	Deductibles		0	0	32.00
33.00	Coinurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		6,363,780	0	36.00
37.00	INTERIM PAYMENT RECONCILIATION		-3,361,501	0	37.00
38.00	Subtotal (line 36 ± line 37)		3,002,279	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		3,002,279	0	40.00
41.00	Interim payments		3,002,279	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0095 Component CCN: 14-S095	Period: From 07/01/2019 To 06/30/2020	Worksheet E-3 Part VII Date/Time Prepared: 1/28/2021 12:08 pm
		Title XIX	Subprovider - IPF	Cost
		Inpatient 1.00	Outpatient 2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				
COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services	0		1.00
2.00	Medical and other services		0	2.00
3.00	Organ acquisition (certified transplant centers only)	0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	0	4.00
5.00	Inpatient primary payer payments	0		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	0	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable Charges				
8.00	Routine service charges	0		8.00
9.00	Ancillary service charges	0	0	9.00
10.00	Organ acquisition charges, net of revenue	0		10.00
11.00	Incentive from target amount computation	0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)	0	0	12.00
CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for services on a charge basis	0	0	13.00
14.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)	0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)	0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)	0	0	18.00
19.00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				
22.00	Other than outlier payments	0	0	22.00
23.00	Outlier payments	0	0	23.00
24.00	Program capital payments	0	0	24.00
25.00	Capital exception payments (see instructions)	0	0	25.00
26.00	Routine and Ancillary service other pass through costs	0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)	0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)	0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)	0	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	0	31.00
32.00	Deductibles	0	0	32.00
33.00	Coinsurance	0	0	33.00
34.00	Allowable bad debts (see instructions)	0	0	34.00
35.00	Utilization review	0	0	35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37.00
38.00	Subtotal (line 36 ± line 37)	0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0	0	39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	0	0	40.00
41.00	Interim payments	0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)	0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2	0	0	43.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0095		Period: From 07/01/2019 To 06/30/2020		Worksheet E-4 Date/Time Prepared: 1/28/2021 12:08 pm	
		Title XVIII		Hospital		PPS	
						1.00	
COMPUTATION OF TOTAL DIRECT GME AMOUNT							
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.					5.59	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)					0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA					2.33	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)					1.17	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))					0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)					0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)					0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts)					2.09	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)					3.11	6.00
7.00	Enter the lesser of line 5 or line 6					2.09	7.00
		Primary Care		Other		Total	
		1.00		2.00		3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	3.11		0.00		3.11	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	2.09		0.00		2.09	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year			1.63			10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year			1.63			10.01
11.00	Total weighted FTE count	2.09		1.63			11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	2.09		1.56			12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	2.09		0.98			13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	2.09		1.39			14.00
15.00	Adjustment for residents in initial years of new programs	0.00		0.00			15.00
15.01	Unweighted adjustment for residents in initial years of new programs	0.00		0.00			15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00		0.00			16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00		0.00			16.01
17.00	Adjusted rolling average FTE count	2.09		1.39			17.00
18.00	Per resident amount	154,837.33		145,757.34			18.00
19.00	Approved amount for resident costs	323,610		202,603		526,213	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)					1.02	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)					526,213	25.00
		Inpatient Part A		Managed Care Prior to 1/1		Managed Care On or after 1/1	
		1.00		2.00		2.01	
						3.00	
COMPUTATION OF PROGRAM PATIENT LOAD							
26.00	Inpatient Days (see instructions)	3,327		0		0	
27.00	Total Inpatient Days (see instructions)	27,248		27,248		27,248	
28.00	Ratio of inpatient days to total inpatient days	0.122101		0.000000		0.000000	
29.00	Program direct GME amount	64,251		0		0	
29.01	Percent reduction for MA DGME			7.00		7.00	
30.00	Reduction for direct GME payments for Medicare Advantage			0		0	
31.00	Net Program direct GME amount					64,251	

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0095	Period: From 07/01/2019 To 06/30/2020	Worksheet E-4 Date/Time Prepared: 1/28/2021 12:08 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)		6,361,904	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)		6,361,904	41.00
Part B Reasonable Cost				
42.00	Reasonable cost (see instructions)		4,369,105	42.00
43.00	Primary payer payments (see instructions)		77	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)		4,369,028	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)		10,730,932	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)		0.592857	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)		0.407143	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48.00	Total program GME payment (line 31)		64,251	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)		38,092	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)		26,159	50.00

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

Provider CCN: 14-0095

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

Worksheet G

Date/Time Prepared:
1/28/2021 12:08 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	33,726,383	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	103,421,511	0	0	0	4.00
5.00	Other receivable	2,351,357	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-87,379,192	0	0	0	6.00
7.00	Inventory	2,124,333	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	646,266	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)	54,890,658	0	0	0	11.00
FIXED ASSETS						
12.00	Land	991,639	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	33,439,753	0	0	0	15.00
16.00	Accumulated depreciation	-26,740,189	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	42,156,982	0	0	0	23.00
24.00	Accumulated depreciation	-33,710,945	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)	16,137,240	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	7,594,684	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	32,045,976	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	39,640,660	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	110,668,558	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	55,248,465	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	2,931,946	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	18,983,609	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	77,164,020	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	10,937,023	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	10,937,023	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	88,101,043	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	22,567,515				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)	22,567,515	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	110,668,558	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0095

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

Worksheet G-1

Date/Time Prepared:
1/28/2021 12:08 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		38,714,395		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		-16,146,880				2.00
3.00	Total (sum of line 1 and line 2)		22,567,515		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)		22,567,515		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)		22,567,515		0		19.00
		Endowment Fund	Plant Fund				
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-0095

Period:
From 07/01/2019
To 06/30/2020Worksheet G-2
Parts I & II
Date/Time Prepared:
1/28/2021 12:08 pm

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	26,392,957		26,392,957	1.00
2.00	SUBPROVIDER - IPF	14,472,293		14,472,293	2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	40,865,250		40,865,250	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	12,111,431		12,111,431	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)	12,111,431		12,111,431	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	52,976,681		52,976,681	17.00
18.00	Ancillary services	102,135,042		102,135,042	18.00
19.00	Outpatient services	0	191,289,483	191,289,483	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
24.20	OUTPATIENT PHYSICAL THERAPY	0	0	0	24.20
24.30	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	24.30
24.40	OUTPATIENT SPEECH PATHOLOGY	0	0	0	24.40
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	155,111,723	191,289,483	346,401,206	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		121,840,756		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	PROVIDER ASSESSMENT TAX	6,365,172			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)		6,365,172		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		115,475,584		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0095

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

Worksheet G-3

Date/Time Prepared:
1/28/2021 12:08 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	346,401,206	1.00
2.00	Less contractual allowances and discounts on patients' accounts	257,774,808	2.00
3.00	Net patient revenues (line 1 minus line 2)	88,626,398	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	115,475,584	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-26,849,186	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	750,195	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	942	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MED STUDENT PROG - OTH OPER REV	1,328,200	24.00
24.01	VOCA GRANT - OTH OPER REV	632,572	24.01
24.02	CSDC MGMT FEES	1,084,557	24.02
24.03	STATE CAPTIAL GRANT	5,000,000	24.03
24.04	ESPERANZA LV - RENTAL	155,384	24.04
24.05	OTHER OPERATING REV	1,750,456	24.05
24.50	COVID-19 PHE Funding	0	24.50
25.00	Total other income (sum of lines 6-24)	10,702,306	25.00
26.00	Total (line 5 plus line 25)	-16,146,880	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)	-16,146,880	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0095	Period: From 07/01/2019 To 06/30/2020	Worksheet L Parts I-III Date/Time Prepared: 1/28/2021 12:08 pm
		Title XVIII	Hospital	PPS
		1.00		
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		281,074	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		1,192	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)		50.52	3.00
4.00	Number of interns & residents (see instructions)		3.48	4.00
5.00	Indirect medical education percentage (see instructions)		1.96	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)		5,509	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		21.59	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		59.55	8.00
9.00	Sum of lines 7 and 8		81.14	9.00
10.00	Allowable disproportionate share percentage (see instructions)		17.86	10.00
11.00	Disproportionate share adjustment (see instructions)		50,200	11.00
12.00	Total prospective capital payments (see instructions)		337,975	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