

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: 14-0179	Period: From 07/01/2019 To 01/31/2020	Worksheet S Parts I-III Date/Time Prepared: 7/28/2020 8:27 am
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PART I - COST REPORT STATUS

Provider use only	1. ☒ Electronically prepared cost report	Date: 7/28/2020	Time: 8:27 am
	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 LITTLE COMPANY OF MARY (14-0179) for the cost reporting period beginning 07/01/2019 and ending 01/31/2020 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

(Signed)

Officer or Administrator of Provider(s)

Title

Date

Cost Center Description		Title V	Title XVIII		HIT	Title XIX	
			Part A	Part B			
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	243,267	21,668	0	0	1.00
2.00	Subprovider - IPF	0	32,518	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
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00	Total	0	275,785	21,668	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: 14-0179	Period: From 07/01/2019 To 01/31/2020	Worksheet S-2 Part I Date/Time Prepared: 7/28/2020 8:27 am	
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	1.00		2.00		3.00		4.00		7/20/2020 3:21 am			
	Hospital and Hospital Health Care Complex Address:											
1.00	Street:2800 WEST 95TH STREET			PO Box:					1.00			
2.00	City: EVERGREEN PARK			State: IL		Zip Code: 60642		County: COOK				
			Component Name		CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
									V	XVIII	XIX	
			1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00	
Hospital and Hospital-Based Component Identification:												
3.00	Hospital		LITTLE COMPANY OF MARY		140179	16974	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF		LITTLE COMPANY OF MARY PSYCH		14S179	16974	4	07/01/1984	N	P	N	4.00
5.00	Subprovider - IRF				147404	16974		01/11/1985	N	P	N	5.00
6.00	Subprovider - (Other)											6.00
7.00	Swing Beds - SNF											7.00
8.00	Swing Beds - NF											8.00
9.00	Hospital-Based SNF											9.00
10.00	Hospital-Based NF											10.00
11.00	Hospital-Based OLTC											11.00
12.00	Hospital-Based HHA											12.00
13.00	Separately Certified ASC											13.00
14.00	Hospital-Based Hospice											14.00
15.00	Hospital-Based Health Clinic - RHC			141511	16974		12/30/1986				15.00	
16.00	Hospital-Based Health Clinic - FQHC										16.00	
17.00	Hospital-Based (CMHC) I										17.00	
17.10	Hospital-Based (CORF) I										17.10	
17.20	Hospital-Based (OPT) I										17.20	
17.30	Hospital-Based (OOT) I										17.30	
17.40	Hospital-Based (OSP) I										17.40	
18.00	Renal Dialysis										18.00	
19.00	Other										19.00	
											From:	
								1.00		2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)							07/01/2019		01/31/2020		20.00
21.00	Type of Control (see instructions)							1				21.00
						1.00		2.00		3.00		

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

Worksheet S-2
Part I
Date/Time Prepared:
7/28/2020 8:27 am

MCRIF32 - 16.1.168.2

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0179		Period: From 07/01/2019 To 01/31/2020		Worksheet S-2 Part I Date/Time Prepared: 7/28/2020 8:27 am	
			NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code		
			1.00	2.00	3.00		
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2.		N				60.00
			Y/N	IME	Direct GME	IME	Direct GME
			1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)		N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06
			Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
			1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.10
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
62.00	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)					0.00	62.00
62.01	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)					0.00	62.01
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)						
63.00	Teaching Hospitals that Claim Residents in Nonprovider Settings						
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)					N	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.					0.00	0.00
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)					0.000000	64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0179

Period:
From 07/01/2019
To 01/31/2020Worksheet S-2
Part I
Date/Time Prepared:
7/28/2020 8:27 am

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0179	Period: From 07/01/2019 To 01/31/2020	Worksheet S-2 Part I Date/Time Prepared: 7/28/2020 8:27 am		
			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.			N 86.00		
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.			N 87.00		
			V	XIX		
			1.00	2.00		
Title V and XIX Services						
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N Y 90.00		
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N N 91.00		
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N 92.00		
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N N 93.00		
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N N 94.00		
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.			0.00 0.00 95.00		
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.			N N 96.00		
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.			0.00 0.00 97.00		
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			N N 98.00		
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			N N 98.01		
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			N N 98.02		
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			N N 98.03		
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			N N 98.04		
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			N N 98.05		
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.			N N 98.06		
Rural Providers						
105.00	Does this hospital qualify as a CAH?			N 105.00		
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00		
107.00	Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train I&Rs in an approved medical education program in the CAH's excluded IPF and/or IRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)			107.00		
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			N 108.00		
			Physical	Occupational	Speech	Respiratory
			1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					
			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		0 115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N		116.00
117.00	Is this facility legally required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N		117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	0		118.00
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	0	13,729,000	0 118.01
		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
Transplant Center Information				
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	Removed and reserved			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
All Providers				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA				Provider CCN: 14-0179		Period: From 07/01/2019 To 01/31/2020		Worksheet S-2 Part I Date/Time Prepared: 7/28/2020 8:27 am		
1.00		2.00		3.00						
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.										
141.00	Name:	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.				Y				145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.				N				146.00	
								1.00		
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.							N	147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.							N	148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.							N	149.00	
				Part A	Part B	Title V	Title XIX			
				1.00	2.00	3.00	4.00			
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)										
155.00	Hospital	N		N		N		N		155.00
156.00	Subprovider - IPF	N		N		N		N		156.00
157.00	Subprovider - IRF	N		N		N		N		157.00
158.00	SUBPROVIDER									158.00
159.00	SNF	N		N		N		N		159.00
160.00	HOME HEALTH AGENCY	N		N		N		N		160.00
161.00	CMHC			N		N		N		161.00
161.10	CORF			N		N		N		161.10
161.20	OUTPATIENT PHYSICAL THERAPY			N		N		N		161.20
161.30	OUTPATIENT OCCUPATIONAL THERAPY			N		N		N		161.30
161.40	OUTPATIENT SPEECH PATHOLOGY			N		N		N		161.40
								1.00		
Multicampus										
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.							N	165.00	
		Name	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			166.00
								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	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 14-0179

Period:
From 07/01/2019
To 01/31/2020Worksheet S-2
Part II
Date/Time Prepared:
7/28/2020 8:27 am

		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	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.	Y		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
		1.00	2.00	3.00
		4.00		
PS&R Data				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	10/05/2012	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

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		Description	Y/N	Y/N	
		0	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N	N	20.00
		Y/N	Date	Y/N	Date
		1.00	2.00	3.00	4.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N	21.00
				1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
		Y/N	Date		
		1.00	2.00		
Home Office Costs					
36.00	Were home office costs claimed on the cost report?				36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
		1.00	2.00		
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MICHAEL	CADDICK		41.00
42.00	Enter the employer/company name of the cost report preparer.	STRATEGIC REIMBURSEMENT, INC.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	708 466-7240	MICHAEL.CADDICK@SRINC.ORG		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0179	Period: From 07/01/2019 To 01/31/2020	Worksheet S-2 Part II Date/Time Prepared: 7/28/2020 8:27 am
		3.00		
Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	VICE PRESIDENT		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: 14-0179

Period:
From 07/01/2019
To 01/31/2020Worksheet S-3
Part I
Date/Time Prepared:
7/28/2020 8:27 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	184	39,560	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)		184	39,560	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	26	5,590	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
11.10 NICU	34.10	10	2,150	0.00	0	11.10
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		220	47,300	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	24	5,160		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	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	116.00	0	0			24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	99.10				0	25.10
25.20 CMHC - OUTPATIENT PHYSICAL THERAPY	99.20				0	25.20
25.30 CMHC - OUTPATIENT OCCUPATIONAL THERAPY	99.30				0	25.30
25.40 CMHC - OUTPATIENT SPEECH PATHOLOGY	99.40				0	25.40
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		244				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: 14-0179

Period:
From 07/01/2019
To 01/31/2020Worksheet S-3
Part I
Date/Time Prepared:
7/28/2020 8:27 am

Component		I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	10,216	1,325	27,871			1.00
2.00	HMO and other (see instructions)	5,629	7,875				2.00
3.00	HMO IPF Subprovider	15	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)	10,216	1,325	27,871			7.00
8.00	INTENSIVE CARE UNIT	886	0	2,709			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
11.10	NICU	0	603	867			11.10
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		216	1,039			13.00
14.00	Total (see instructions)	11,102	2,144	32,486	1.81	1,459.61	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	322	0	1,227	0.00	14.62	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	5,168	0	8,874	0.00	17.06	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE	0	0	0	0.00	11.00	24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	0	0	0	0.00	0.00	25.10
25.20	CMHC - OUTPATIENT PHYSICAL THERAPY	0	0	0	0.00	0.00	25.20
25.30	CMHC - OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0.00	0.00	25.30
25.40	CMHC - OUTPATIENT SPEECH PATHOLOGY	0	0	0	0.00	0.00	25.40
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				1.81	1,502.29	27.00
28.00	Observation Bed Days		0	4,836			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			182			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	20	30			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: 14-0179

Period:
From 07/01/2019
To 01/31/2020Worksheet S-3
Part I
Date/Time Prepared:
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Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00	15.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	2,252	492	6,681	1.00
2.00 HMO and other (see instructions)			992	1,065		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
11.10 NICU						11.10
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	2,252	492	6,681	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	51	0	249	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	0.00					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE	0.00					24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	0.00					25.10
25.20 CMHC - OUTPATIENT PHYSICAL THERAPY	0.00					25.20
25.30 CMHC - OUTPATIENT OCCUPATIONAL THERAPY	0.00					25.30
25.40 CMHC - OUTPATIENT SPEECH PATHOLOGY	0.00					25.40
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days			0			33.00
33.01 LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0179

Period:
From 07/01/2019
To 01/31/2020Worksheet S-3
Part II
Date/Time Prepared:
7/28/2020 8:27 am

	Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART II - WAGE DATA							
SALARIES							
1.00	Total salaries (see instructions)	200.00	59,692,312	0	59,692,312	1,882,766.00	31.70
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non Physician-Part B		944,209	0	944,209	9,249.00	102.09
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)		62,233	0	62,233	4,807.00	12.95
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)		2,340,187	-45,922	2,294,265	58,038.00	39.53
OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		2,080,798	0	2,080,798	26,225.00	79.34
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		318,020	0	318,020	1,299.00	244.82
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)		13,111,622	0	13,111,622		
18.00	Wage-related costs (other) (see instructions)						
19.00	Excluded areas		536,176	0	536,176		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		128,918	0	128,918		
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: 14-0179

Period:
From 07/01/2019
To 01/31/2020Worksheet S-3
Part II
Date/Time Prepared:
7/28/2020 8:27 am

		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
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	735,158	0	735,158	18,392.00	39.97	26.00
27.00	Administrative & General	5.00	9,121,160	-332,457	8,788,703	265,373.00	33.12	27.00
28.00	Administrative & General under contract (see inst.)		120	0	120	29,725.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	1,582,168	0	1,582,168	63,818.00	24.79	30.00
31.00	Laundry & Linen Service	8.00	90,238	0	90,238	0.00	0.00	31.00
32.00	Housekeeping	9.00	1,171,870	0	1,171,870	73,526.00	15.94	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	821,351	-382,646	438,705	21,993.00	19.95	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	382,646	382,646	19,183.00	19.95	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,148,230	0	1,148,230	32,107.00	35.76	38.00
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00	39.00
40.00	Pharmacy	15.00	1,885,882	0	1,885,882	40,365.00	46.72	40.00
41.00	Medical Records & Medical Records Library	16.00	2,078,563	0	2,078,563	65,198.00	31.88	41.00
42.00	Social Service	17.00	0	532,959	532,959	12,738.00	41.84	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0179

Period:
From 07/01/2019
To 01/31/2020Worksheet S-3
Part III
Date/Time Prepared:
7/28/2020 8:27 am

	Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	58,685,990	0	58,685,990	1,898,435.00	30.91	1.00
2.00	Excluded area salaries (see instructions)	2,340,187	-45,922	2,294,265	58,038.00	39.53	2.00
3.00	Subtotal salaries (line 1 minus line 2)	56,345,803	45,922	56,391,725	1,840,397.00	30.64	3.00
4.00	Subtotal other wages & related costs (see inst.)	2,398,818	0	2,398,818	27,524.00	87.15	4.00
5.00	Subtotal wage-related costs (see inst.)	13,111,622	0	13,111,622	0.00	23.25	5.00
6.00	Total (sum of lines 3 thru 5)	71,856,243	45,922	71,902,165	1,867,921.00	38.49	6.00
7.00	Total overhead cost (see instructions)	18,634,740	200,502	18,835,242	642,418.00	29.32	7.00

HOSPITAL WAGE RELATED COSTS

Provider CCN: 14-0179

Period:
From 07/01/2019
To 01/31/2020Worksheet S-3
Part IV
Date/Time Prepared:
7/28/2020 8:27 am

		Amount Reported	
		1.00	
PART IV - WAGE RELATED COSTS			
Part A - Core List			
RETIREMENT COST			
1.00	401K Employer Contributions	1,004,434	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	31,729	6.00
7.00	Employee Managed Care Program Administration Fees	42,368	7.00
HEALTH AND INSURANCE COST			
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	6,798,743	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	137,801	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	78,081	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)	411,535	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	658,771	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	4,506,409	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	30,688	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	76,157	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	13,776,716	24.00
Part B - Other than Core Related Cost			
25.00	OTHER WAGE RELATED COST		25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 14-0179

Period:
From 07/01/2019
To 01/31/2020Worksheet S-3
Part V
Date/Time Prepared:
7/28/2020 8:27 am

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	1,794,634	22,385,493	1.00
2.00	Hospital	1,794,634	21,092,352	2.00
3.00	Subprovider - IPF	0	312,520	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	0	376,603	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice	0	219,862	13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
16.10	Hospital-Based-CMHC 10	0	0	16.10
16.20	Hospital-Based-CMHC 20	0	0	16.20
16.30	Hospital-Based-CMHC 30	0	0	16.30
16.40	Hospital-Based-CMHC 40	0	0	16.40
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	384,156	18.00

HOME HEALTH AGENCY STATISTICAL DATA				Provider CCN: 14-0179 Component CCN: 14-7404		Period: From 07/01/2019 To 01/31/2020		Worksheet S-4 Date/Time Prepared: 7/28/2020 8:27 am		
						Home Health Agency I		PPS		
						1.00				
0.00	County				11				0.00	
				Title V	Title XVIII	Title XIX	Other	Total		
				1.00	2.00	3.00	4.00	5.00		
HOME HEALTH AGENCY STATISTICAL DATA										
1.00	Home Health Aide Hours				0	213	0	320	533	1.00
2.00	Unduplicated Census Count (see instructions)				0.00	209.00	0.00	150.00	359.00	2.00
						Number of Employees (Full Time Equivalent)				
				Enter the number of hours in your normal work week		Staff	Contract	Total		
				0		1.00	2.00	3.00		
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES										
3.00	Administrator and Assistant Administrator(s)				40.00	0.00	0.00	0.00	3.00	
4.00	Director(s) and Assistant Director(s)					1.17	0.00	1.17	4.00	
5.00	Other Administrative Personnel					4.99	0.00	4.99	5.00	
6.00	Direct Nursing Service					4.66	0.00	4.66	6.00	
7.00	Nursing Supervisor					0.00	0.00	0.00	7.00	
8.00	Physical Therapy Service					2.73	1.20	3.93	8.00	
9.00	Physical Therapy Supervisor					0.00	0.00	0.00	9.00	
10.00	Occupational Therapy Service					0.83	0.00	0.83	10.00	
11.00	Occupational Therapy Supervisor					0.00	0.00	0.00	11.00	
12.00	Speech Pathology Service					0.00	0.02	0.02	12.00	
13.00	Speech Pathology Supervisor					0.00	0.00	0.00	13.00	
14.00	Medical Social Service					0.28	0.00	0.28	14.00	
15.00	Medical Social Service Supervisor					0.00	0.00	0.00	15.00	
16.00	Home Health Aide					0.58	0.00	0.58	16.00	
17.00	Home Health Aide Supervisor					0.00	0.00	0.00	17.00	
18.00	Other (specify)					0.00	0.00	0.00	18.00	
HOME HEALTH AGENCY CBSA CODES										
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.				1				19.00	
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).				16974				20.00	
				Full Episodes						
				Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)		
				1.00	2.00	3.00	4.00	5.00		
PPS ACTIVITY DATA										
21.00	Skilled Nursing Visits				1,725	286	98	0	2,109	21.00
22.00	Skilled Nursing Visit Charges				508,875	84,370	28,910	0	622,155	22.00
23.00	Physical Therapy Visits				1,866	170	27	0	2,063	23.00
24.00	Physical Therapy Visit Charges				578,460	52,700	8,370	0	639,530	24.00
25.00	Occupational Therapy Visits				656	83	2	0	741	25.00
26.00	Occupational Therapy Visit Charges				197,780	25,730	620	0	224,130	26.00
27.00	Speech Pathology Visits				7	3	0	0	10	27.00
28.00	Speech Pathology Visit Charges				2,170	930	0	0	3,100	28.00
29.00	Medical Social Service Visits				28	3	1	0	32	29.00
30.00	Medical Social Service Visit Charges				11,200	1,200	400	0	12,800	30.00
31.00	Home Health Aide Visits				152	61	0	0	213	31.00
32.00	Home Health Aide Visit Charges				30,400	12,200	0	0	42,600	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)				4,434	606	128	0	5,168	33.00
34.00	Other Charges				0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)				1,328,885	177,130	38,300	0	1,544,315	35.00
36.00	Total Number of Episodes (standard/non outlier)				237		47	0	284	36.00
37.00	Total Number of Outlier Episodes					14		0	14	37.00
38.00	Total Non-Routine Medical Supply Charges				65,747	3,275	4,397	0	73,419	38.00

HOSPITAL-BASED HOSPICE IDENTIFICATION DATA			Provider CCN: 14-0179 Hospice CCN: 14-1511	Period: From 07/01/2019 To 01/31/2020	Worksheet S-9 PARTS I THROUGH IV Date/Time Prepared: 7/28/2020 8:27 am
			Hospice I		

		Unduplicated Days					Hospice 1			
		Title XVIII	Title XIX	Title XVIII Skilled Nursing Facility	Title XIX Nursing Facility	All Other	Total (sum of cols. 1, 2 & 5)			
		1.00	2.00	3.00	4.00	5.00	6.00			
	PART I - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015									
1.00	Hospice Continuous Home Care								1.00	
2.00	Hospice Routine Home Care								2.00	
3.00	Hospice Inpatient Respite Care								3.00	
4.00	Hospice General Inpatient Care								4.00	
5.00	Total Hospice Days								5.00	
	Part II - CENSUS DATA FOR COST REPORTING PERIODS BEGINNING BEFORE OCTOBER 1, 2015									
6.00	Number of patients receiving hospice care								6.00	
7.00	Total number of unduplicated Continuous Care hours billable to Medicare								7.00	
8.00	Average Length of Stay (line 5 / line 6)								8.00	
9.00	Unduplicated census count								9.00	

NOTE: Parts I and II, columns 1 and 2 also include the days reported in columns 3 and 4.

		Title XVIII	Title XIX	Other	Total (sum of cols. 1 through 3)	
		1.00	2.00	3.00	4.00	
	PART III - ENROLLMENT DAYS FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015					
10.00	Hospice Continuous Home Care	3,307	0	179	3,486	10.00
11.00	Hospice Routine Home Care	0	0	0	0	11.00
12.00	Hospice Inpatient Respite Care	0	0	0	0	12.00
13.00	Hospice General Inpatient Care	158	0	0	158	13.00
14.00	Total Hospice Days	3,465	0	179	3,644	14.00
	PART IV - CONTRACTED STATISTICAL DATA FOR COST REPORTING PERIODS BEGINNING ON OR AFTER OCTOBER 1, 2015					
15.00	Hospice Inpatient Respite Care	0	0	0	0	15.00
16.00	Hospice General Inpatient Care	0	0	0	0	16.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

Provider CCN: 14-0179

Period:
From 07/01/2019
To 01/31/2020

Worksheet S-10

Date/Time Prepared:
7/28/2020 8:27 am

				1.00	
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.209433		1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		22,369,923		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		114,257,304		6.00
7.00	Medicaid cost (line 1 times line 6)		23,929,250		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)		1,559,327		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)		1,559,327		19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
Uncompensated Care (see instructions for each line)					
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	23,333,281	3,846,837	27,180,118	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	4,886,759	3,846,837	8,733,596	21.00
22.00	Payments received from patients for amounts previously written off as charity care	145,059	52,250	197,309	22.00
23.00	Cost of charity care (line 21 minus line 22)	4,741,700	3,794,587	8,536,287	23.00
				1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N		24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit		0		25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)		2,911,064		26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)		614,115		27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)		944,794		27.01
28.00	Non-Medicare bad debt expense (see instructions)		1,966,270		28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)		742,481		29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		9,278,768		30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		10,838,095		31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0179

Period:
From 07/01/2019
To 01/31/2020

Worksheet A

Date/Time Prepared:
7/28/2020 8:27 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassification ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT		5,444,413	5,444,413	2,474,813	7,919,226	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		3,648,680	3,648,680	0	3,648,680	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	735,158	977,825	1,712,983	0	1,712,983	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	9,121,160	30,352,615	39,473,775	-423,047	39,050,728	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	1,582,168	3,149,465	4,731,633	0	4,731,633	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	90,238	187,570	277,808	0	277,808	8.00
9.00	00900	HOUSEKEEPING	1,171,870	606,892	1,778,762	0	1,778,762	9.00
10.00	01000	DIETARY	821,351	817,134	1,638,485	-763,327	875,158	10.00
11.00	01100	CAFETERIA	0	0	0	763,327	763,327	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	1,148,230	621,762	1,769,992	0	1,769,992	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	-461,839	-461,839	14.00
15.00	01500	PHARMACY	1,885,882	9,958,130	11,844,012	-9,191,227	2,652,785	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,078,563	1,415,669	3,494,232	0	3,494,232	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	681,868	681,868	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	62,233	62,233	0	62,233	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	13,070,208	4,492,643	17,562,851	-461,605	17,101,246	30.00
31.00	03100	INTENSIVE CARE UNIT	2,103,385	1,004,516	3,107,901	0	3,107,901	31.00
34.10	02060	NICU	664,266	1,263,698	1,927,964	0	1,927,964	34.10
40.00	04000	SUBPROVIDER - IPF	708,176	190,986	899,162	0	899,162	40.00
43.00	04300	NURSERY	0	0	0	461,605	461,605	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,841,998	6,203,015	9,045,013	-3,519,627	5,525,386	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,244,438	531,818	1,776,256	0	1,776,256	52.00
53.00	05300	ANESTHESIOLOGY	69,352	2,023,306	2,092,658	0	2,092,658	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,009,240	2,188,566	4,197,806	-1,462,457	2,735,349	54.00
54.01	03440	BREAST HEALTH CENTER	0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	749,559	841,079	1,590,638	0	1,590,638	55.00
56.00	05600	RADIOISOTOPE	249,100	576,344	825,444	66,141	891,585	56.00
56.10	03630	ULTRASOUND	553,675	282,753	836,428	65,383	901,811	56.10
57.00	05700	CT SCAN	476,954	427,367	904,321	4,243	908,564	57.00
58.00	05800	MRI	218,465	257,146	475,611	86,656	562,267	58.00
59.00	05900	CARDIAC CATHETERIZATION	454,369	2,168,794	2,623,163	-1,592,888	1,030,275	59.00
60.00	06000	LABORATORY	2,311,793	3,996,207	6,308,000	0	6,308,000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,323,676	596,940	1,920,616	-160,299	1,760,317	65.00
65.01	03952	SLEEP LAB	119,789	49,223	169,012	0	169,012	65.01
66.00	06600	PHYSICAL THERAPY	1,061,485	327,104	1,388,589	0	1,388,589	66.00
68.00	06800	SPEECH PATHOLOGY	195,576	40,985	236,561	0	236,561	68.00
69.00	06900	ELECTROCARDIOLOGY	810,648	453,257	1,263,905	0	1,263,905	69.00
69.01	06901	C-PORT	0	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	94,431	29,966	124,397	0	124,397	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	319,976	742,190	1,062,166	3,645,494	4,707,660	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3,062,450	3,062,450	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	9,191,227	9,191,227	73.00
74.00	07400	RENAL DIALYSIS	486,530	253,471	740,001	0	740,001	74.00
75.10	03340	GI LAB	776,186	646,529	1,422,715	-123,966	1,298,749	75.10
76.00	03951	ENTEROSTOMAL THERAPY	0	0	0	0	0	76.00
76.10	03950	NEUROLOGY	0	0	0	0	0	76.10
76.20	03290	EMG	0	0	0	0	0	76.20
76.30	03953	OS SVCS	0	20,282	20,282	0	20,282	76.30
76.40	03040	AUDIOLOGY	0	0	0	0	0	76.40
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	337,866	161,580	499,446	0	499,446	90.00
90.01	09001	PALOS DIAGNOSTIC CENTER	71,469	60,200	131,669	0	131,669	90.01
90.02	09002	CARE STATIONS	1,210,172	647,896	1,858,068	0	1,858,068	90.02
90.03	09003	OUTPATIENT CARE CENTER	859,244	846,113	1,705,357	142,939	1,848,296	90.03
91.00	09100	EMERGENCY	3,029,664	2,628,203	5,657,867	0	5,657,867	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04951	OUTPATIENT REHAB	625,389	180,715	806,104	0	806,104	93.00
93.10	04950	WOUND CARE CENTER	378,602	202,531	581,133	0	581,133	93.10

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0179

Period:
From 07/01/2019
To 01/31/2020

Worksheet A

Date/Time Prepared:
7/28/2020 8:27 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 + col. 4)	
			1.00	2.00	3.00	4.00	5.00	
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	916,420	528,656	1,445,076	-47,549	1,397,527	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE		2,425,594	2,425,594	-2,425,594	0	113.00
116.00	11600	HOSPICE	511,054	364,002	875,056	-12,721	862,335	116.00
117.00	06950	MOBILE MED	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	59,487,775	94,896,063	154,383,838	0	154,383,838	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.10	19101	ADULT DAY CARE	0	0	0	0	0	191.10
192.00	19200	PHYSICIANS' PRIVATE OFFICES	204,537	263,007	467,544	0	467,544	192.00
192.01	19201	VACANT SPACE	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	FUND DEVELOPMENT	0	0	0	0	0	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	59,692,312	95,159,070	154,851,382	0	154,851,382	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0179

Period:
From 07/01/2019
To 01/31/2020

Worksheet A

Date/Time Prepared:
7/28/2020 8:27 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-2,456,644	5,462,582	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	-20,387	3,628,293	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-403	1,712,580	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-12,981,082	26,069,646	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	6.00
7.00	00700	OPERATION OF PLANT	0	4,731,633	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	277,808	8.00
9.00	00900	HOUSEKEEPING	-2,730	1,776,032	9.00
10.00	01000	DIETARY	-10,996	864,162	10.00
11.00	01100	CAFETERIA	-403,816	359,511	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	1,769,992	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	-461,839	14.00
15.00	01500	PHARMACY	-125,701	2,527,084	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-2,371	3,491,861	16.00
17.00	01700	SOCIAL SERVICE	0	681,868	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	62,233	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-544,382	16,556,864	30.00
31.00	03100	INTENSIVE CARE UNIT	-13,233	3,094,668	31.00
34.10	02060	NICU	-998,716	929,248	34.10
40.00	04000	SUBPROVIDER - IPF	-20,191	878,971	40.00
43.00	04300	NURSERY	0	461,605	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-398,980	5,126,406	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,776,256	52.00
53.00	05300	ANESTHESIOLOGY	-1,804,866	287,792	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-36,224	2,699,125	54.00
54.01	03440	BREAST HEALTH CENTER	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	1,590,638	55.00
56.00	05600	RADIOISOTOPE	0	891,585	56.00
56.10	03630	ULTRASOUND	0	901,811	56.10
57.00	05700	CT SCAN	0	908,564	57.00
58.00	05800	MRI	0	562,267	58.00
59.00	05900	CARDIAC CATHETERIZATION	-129,248	901,027	59.00
60.00	06000	LABORATORY	-21,182	6,286,818	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	-13,506	1,746,811	65.00
65.01	03952	SLEEP LAB	0	169,012	65.01
66.00	06600	PHYSICAL THERAPY	0	1,388,589	66.00
68.00	06800	SPEECH PATHOLOGY	0	236,561	68.00
69.00	06900	ELECTROCARDIOLOGY	-17,836	1,246,069	69.00
69.01	06901	C-PORT	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	124,397	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	-585	4,707,075	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	3,062,450	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	9,191,227	73.00
74.00	07400	RENAL DIALYSIS	-4,953	735,048	74.00
75.10	03340	GI LAB	0	1,298,749	75.10
76.00	03951	ENTEROSTOMAL THERAPY	0	0	76.00
76.10	03950	NEUROLOGY	0	0	76.10
76.20	03290	EMG	0	0	76.20
76.30	03953	OS SVCS	-4,946	15,336	76.30
76.40	03040	AUDIOLOGY	0	0	76.40
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	4,196	503,642	90.00
90.01	09001	PALOS DIAGNOSTIC CENTER	0	131,669	90.01
90.02	09002	CARE STATIONS	-389,710	1,468,358	90.02
90.03	09003	OUTPATIENT CARE CENTER	-14,189	1,834,107	90.03
91.00	09100	EMERGENCY	-484,167	5,173,700	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
93.00	04951	OUTPATIENT REHAB	-5,631	800,473	93.00
93.10	04950	WOUND CARE CENTER	-7,538	573,595	93.10
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF	0	0	99.10

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0179

Period:
From 07/01/2019
To 01/31/2020

Worksheet A

Date/Time Prepared:
7/28/2020 8:27 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
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
101.00	10100	HOME HEALTH AGENCY	0	1,397,527	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
116.00	11600	HOSPICE	0	862,335	116.00
117.00	06950	MOBILE MED	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-20,910,017	133,473,821	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
191.10	19101	ADULT DAY CARE	0	0	191.10
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	467,544	192.00
192.01	19201	VACANT SPACE	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	193.00
194.00	07950	FUND DEVELOPMENT	0	0	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-20,910,017	133,941,365	200.00

RECLASSIFICATIONS

Provider CCN: 14-0179

Period:
From 07/01/2019
To 01/31/2020

Worksheet A-6

Date/Time Prepared:
7/28/2020 8:27 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - DRUGS CHGD TO PAT.					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	9,191,227		1.00
	TOTALS		0	9,191,227		
	B - CAFETERIA COSTS					
1.00	CAFETERIA	11.00	382,646	380,681		1.00
	TOTALS		382,646	380,681		
	D - HHA/HOSPICE BILLONG MED REC COSTS					
1.00	ADMINISTRATIVE & GENERAL	5.00	45,922	14,348		1.00
2.00		0.00	0	0		2.00
	TOTALS		45,922	14,348		
	G - INTEREST EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	2,425,594		1.00
	TOTALS		0	2,425,594		
	I - RADIOLOGY ADMIN COSTS					
1.00	RADIOISOTOPE	56.00	38,160	27,981		1.00
2.00	ULTRASOUND	56.10	84,057	61,635		2.00
3.00	CT SCAN	57.00	74,929	54,942		3.00
4.00	MRI	58.00	49,996	36,660		4.00
5.00	OU PATIENT CARE CENTER	90.03	82,469	60,470		5.00
	TOTALS		329,611	241,688		
	J - NURSERY COSTS					
1.00	NURSERY	43.00	328,196	133,409		1.00
	TOTALS		328,196	133,409		
	L - UTIL/QUALITY MANAGEMENT COSTS					
1.00	SOCIAL SERVICE	17.00	532,959	148,909		1.00
	TOTALS		532,959	148,909		
	M - MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	3,893,264		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
7.00		0.00	0	0		7.00
8.00		0.00	0	0		8.00
	TOTALS		0	3,893,264		
	N - MATERIALS MANAGEMENT COSTS					
1.00	ADMINISTRATIVE & GENERAL	5.00	154,580	93,190		1.00
	TOTALS		154,580	93,190		
	O - PROPERTY INSURANCE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	49,219		1.00
	TOTALS		0	49,219		
	P - IMPLANT COSTS					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	3,062,450		1.00
2.00		0.00	0	0		2.00
	TOTALS		0	3,062,450		
500.00	Grand Total: Increases		1,773,914	19,633,979		500.00

RECLASSIFICATIONS

Provider CCN: 14-0179

Period:
From 07/01/2019
To 01/31/2020Worksheet A-6
Date/Time Prepared:
7/28/2020 8:27 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - DRUGS CHGD TO PAT.						
1.00	PHARMACY	15.00	0	9,191,227	0		1.00
	TOTALS		0	9,191,227			
	B - CAFETERIA COSTS						
1.00	DIETARY	10.00	382,646	380,681	0		1.00
	TOTALS		382,646	380,681			
	D - HHA/HOSPICE BILLONG MED REC COSTS						
1.00	HOME HEALTH AGENCY	101.00	36,372	11,177	0		1.00
2.00	HOSPICE	116.00	9,550	3,171	0		2.00
	TOTALS		45,922	14,348			
	G - INTEREST EXPENSE						
1.00	INTEREST EXPENSE	113.00	0	2,425,594	9		1.00
	TOTALS		0	2,425,594			
	I - RADIOLOGY ADMIN COSTS						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	329,611	241,688	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
	TOTALS		329,611	241,688			
	J - NURSERY COSTS						
1.00	ADULTS & PEDIATRICS	30.00	328,196	133,409	0		1.00
	TOTALS		328,196	133,409			
	L - UTIL/QUALITY MANAGEMENT COSTS						
1.00	ADMINISTRATIVE & GENERAL	5.00	532,959	148,909	0		1.00
	TOTALS		532,959	148,909			
	M - MEDICAL SUPPLIES						
1.00	OPERATING ROOM	50.00	0	1,516,870	0		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	891,158	0		2.00
3.00	ULTRASOUND	56.10	0	80,309	0		3.00
4.00	CT SCAN	57.00	0	125,628	0		4.00
5.00	CARDIAC CATHETERIZATION	59.00	0	533,195	0		5.00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	461,839	0		6.00
7.00	GI LAB	75.10	0	123,966	0		7.00
8.00	RESPIRATORY THERAPY	65.00	0	160,299	0		8.00
	TOTALS		0	3,893,264			
	N - MATERIALS MANAGEMENT COSTS						
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	154,580	93,190	0		1.00
	TOTALS		154,580	93,190			
	O - PROPERTY INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	49,219	9		1.00
	TOTALS		0	49,219			
	P - IMPLANT COSTS						
1.00	OPERATING ROOM	50.00	0	2,002,757	0		1.00
2.00	CARDIAC CATHETERIZATION	59.00	0	1,059,693	0		2.00
	TOTALS		0	3,062,450			
500.00	Grand Total: Decreases		1,773,914	19,633,979			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0179

Period:
From 07/01/2019
To 01/31/2020Worksheet A-7
Part I
Date/Time Prepared:
7/28/2020 8:27 am

		Beginning Balances	Acquisitions			Disposals and Retirements		
			Purchases	Donation	Total			
		1.00	2.00	3.00	4.00	5.00		
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	9,018,035	0	0	0	0	1.00	
2.00	Land Improvements	11,108,738	0	0	0	0	2.00	
3.00	Buildings and Fixtures	300,667,411	20,955,366	0	20,955,366	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	103,160,526	8,412,579	0	8,412,579	262,857	6.00	
7.00	HIT designated Assets	0	0	0	0	0	7.00	
8.00	Subtotal (sum of lines 1-7)	423,954,710	29,367,945	0	29,367,945	262,857	8.00	
9.00	Reconciling Items	0	0	0	0	0	9.00	
10.00	Total (line 8 minus line 9)	423,954,710	29,367,945	0	29,367,945	262,857	10.00	
		Ending Balance	Fully Depreciated Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	9,018,035	0				1.00	
2.00	Land Improvements	11,108,738	0				2.00	
3.00	Buildings and Fixtures	321,622,777	0				3.00	
4.00	Building Improvements	0	0				4.00	
5.00	Fixed Equipment	0	0				5.00	
6.00	Movable Equipment	111,310,248	0				6.00	
7.00	HIT designated Assets	0	0				7.00	
8.00	Subtotal (sum of lines 1-7)	453,059,798	0				8.00	
9.00	Reconciling Items	0	0				9.00	
10.00	Total (line 8 minus line 9)	453,059,798	0				10.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0179

Period:
From 07/01/2019
To 01/31/2020Worksheet A-7
Part II
Date/Time Prepared:
7/28/2020 8:27 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	5,444,413	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	3,648,680	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	9,093,093	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other	Total (1) (sum				
		Capital-Related Costs (see instructions)	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	5,444,413				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	3,648,680				2.00
3.00	Total (sum of lines 1-2)	0	9,093,093				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0179

Period:
From 07/01/2019
To 01/31/2020Worksheet A-7
Part III
Date/Time Prepared:
7/28/2020 8:27 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1.000000	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0.000000	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	5,462,582	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	3,628,293	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	9,090,875	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	5,462,582	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	3,628,293	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	9,090,875	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0179

Period:
From 07/01/2019
To 01/31/2020

Worksheet A-8

Date/Time Prepared:
7/28/2020 8:27 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00	2.00	3.00	4.00	5.00			
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	A	-242,559	CAP REL COSTS-BLDG & FIXT	1.00	9	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)	B	-53,117	CAP REL COSTS-BLDG & FIXT	1.00	9	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-51,865	ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-6,951,446			0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00	Related organization transactions (chapter 10)	A-8-1	3,036			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-207	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines	B	-10,996	DIETARY	10.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	*** Cost Center Deleted ***	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 14-0179

Period:
From 07/01/2019
To 01/31/2020

Worksheet A-8

Date/Time Prepared:
7/28/2020 8:27 am

Cost Center Description		Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
				Cost Center	Line #		
1.00		2.00	3.00	4.00	5.00		
33.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.00
33.03	LABORATORY REVENUES	B	-3,003	LABORATORY	60.00	0	33.03
33.04	PHARMACY MISC REVENUE	B	-125,701	PHARMACY	15.00	0	33.04
33.05	RADIOLOGY ADMIN	B	-1,676	RADIOLOGY-DIAGNOSTIC	54.00	0	33.05
33.09	HUMAN RESOURCES MISC REVENUE	B	-403	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.09
33.15	TELE & COMM MISC REVENUE	B	-752	ADMINISTRATIVE & GENERAL	5.00	0	33.15
33.16	ANSWERING SVCE INCOME	B	-123,516	ADMINISTRATIVE & GENERAL	5.00	0	33.16
33.25	CAFETERIA REVENUE	B	-403,816	CAFETERIA	11.00	0	33.25
33.27	MEDICAL STAFF APPLICATION REVEN	B	-48,000	ADMINISTRATIVE & GENERAL	5.00	0	33.27
33.28	HOUSEKEEPING	B	-2,730	HOUSEKEEPING	9.00	0	33.28
33.29	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.29
33.30	BUS OFFICE/ADMITTING REVENUE	B	-1,248	ADMINISTRATIVE & GENERAL	5.00	0	33.30
33.32	HEALTH PROMOTIONS COSTS CHICAGO RIDG	A	-566	ADMINISTRATIVE & GENERAL	5.00	0	33.32
33.33	CLINIC REVENUE	B	-117	CLINIC	90.00	0	33.33
33.39	MATERIALS SERVCS REVENUE	B	-585	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	33.39
33.41	HEALTH EDUCATION CENTER REVENUE	B	-45,206	ADMINISTRATIVE & GENERAL	5.00	0	33.41
33.43	AFFILIATES REVENUE	B	-324,806	ADMINISTRATIVE & GENERAL	5.00	0	33.43
33.45	MISCELLANEOUS REVENUE	B	-269,798	ADMINISTRATIVE & GENERAL	5.00	0	33.45
33.46	REAL ESTATE TAXES	A	-142,740	ADMINISTRATIVE & GENERAL	5.00	0	33.46
33.47	MOTHER BABY REVENUE	B	-1,185	ADULTS & PEDIATRICS	30.00	0	33.47
33.52	NON-ALLOWABLE ADMIN COSTS	A	-1	ADMINISTRATIVE & GENERAL	5.00	9	33.52
33.53	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.53
33.58	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.58
34.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.00
34.01	MEDICAID TAX	A	-6,450,958	ADMINISTRATIVE & GENERAL	5.00	0	34.01
34.02	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.02
34.05	NON-ALLOWABLE DUES	A	-6,186	ADMINISTRATIVE & GENERAL	5.00	9	34.05
34.06	DEPR TELEPHONES, PATIENT PORTIO	A	-15,822	CAP REL COSTS-MVBLE EQUIP	2.00	9	34.06
34.07	NON-ALLOWABLE INTEREST EXPENSE	A	-2,183,034	CAP REL COSTS-BLDG & FIXT	1.00	9	34.07
34.08	MARKETING COSTS	A	-535,074	ADMINISTRATIVE & GENERAL	5.00	9	34.08
34.24	EMPLOYEE HEALTH COSTS	A	-2,904,106	ADMINISTRATIVE & GENERAL	5.00	0	34.24
34.26	PHYSICIAN MATCH DEPR EXPENSE	A	-4,565	CAP REL COSTS-MVBLE EQUIP	2.00	9	34.26
34.40	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.40
34.65	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.65
34.66	OTHER REVENUE	B	-7,269	CARE STATIONS	90.02	0	34.66
34.67	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.67
34.68	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.68
34.69	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	34.69
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-20,910,017				50.00

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

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

Provider CCN: 14-0179

Period:
From 07/01/2019
To 01/31/2020

Worksheet A-8-1

Date/Time Prepared:
7/28/2020 8:27 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:						
1.00	0.00			0	0	1.00
2.00	0.00			0	0	2.00
3.00	1.00	CAP REL COSTS-BLDG & FIXT	POTTER PAV DEPR COSTS	22,066	0	3.00
3.01	5.00	ADMINISTRATIVE & GENERAL	POTTER PAV ADMIN COSTS	4,313	35,433	3.01
3.02	90.00	CLINIC	POTTER PAV ADMIN COSTS	4,313	0	3.02
3.03	90.02	CARE STATIONS	OP CARE CENTER BUILD COST	134,708	107,796	3.03
3.04	90.03	OPATIENT CARE CENTER	OP CARE CENTER BUILD COST	146,974	161,163	3.04
3.05	76.30	OS SVCS	OUTSIDE SERVICES	4,800	9,746	3.05
4.00	0.00		POTTER PAV ADMIN COS	0	0	4.00
4.01	0.00		POTTER PAV COSTS	0	0	4.01
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			317,174	314,138	5.00

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

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

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

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

6.00	C	SW HOSPITAL MRI	0.00		0.00	6.00
7.00	C	LCM INC.	0.00		0.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:				0.00	100.00

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

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

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

Provider CCN: 14-0179

Period:
From 07/01/2019
To 01/31/2020

Worksheet A-8-1

Date/Time Prepared:
7/28/2020 8:27 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	0	0		1.00
2.00	0	0		2.00
3.00	22,066	9		3.00
3.01	-31,120	0		3.01
3.02	4,313	0		3.02
3.03	26,912	0		3.03
3.04	-14,189	0		3.04
3.05	-4,946	0		3.05
4.00	0	0		4.00
4.01	0	0		4.01
5.00	3,036			5.00

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

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

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

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

6.00			6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0179

Period:
From 07/01/2019
To 01/31/2020

Worksheet A-8-2

Date/Time Prepared:
7/28/2020 8:27 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	2,059,757	1,912,513	147,244	177,800	171	1.00
2.00	30.00	ADULTS & PEDIATRICS	543,197	543,197	0	0	0	2.00
3.00	34.10	NICU	998,716	998,716	0	0	0	3.00
4.00	40.00	SUBPROVIDER - IPF	23,183	0	23,183	177,800	35	4.00
5.00	50.00	OPERATING ROOM	398,980	398,980	0	0	0	5.00
6.00	31.00	INTENSIVE CARE UNIT	25,200	0	25,200	177,800	140	6.00
7.00	53.00	ANESTHESIOLOGY	1,804,866	1,804,866	0	0	0	7.00
8.00	54.00	RADIOLOGY-DIAGNOSTIC	34,548	34,548	0	0	0	8.00
9.00	55.00	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	9.00
10.00	59.00	CARDIAC CATHETERIZATION	129,334	0	129,334	177,800	1	10.00
11.00	60.00	LABORATORY	18,179	18,179	0	0	0	11.00
12.00	65.00	RESPIRATORY THERAPY	24,790	0	24,790	177,800	132	12.00
13.00	69.00	ELECTROCARDIOLOGY	50,148	0	50,148	177,800	378	13.00
14.00	74.00	RENAL DIALYSIS	12,390	0	12,390	177,800	87	14.00
15.00	90.02	CARE STATIONS	429,697	397,697	32,000	177,800	238	15.00
16.00	91.00	EMERGENCY	484,167	484,167	0	0	0	16.00
17.00	93.00	OUTPATIENT REHAB	8,623	0	8,623	177,800	35	17.00
18.00	93.10	WOUND CARE CENTER	17,625	0	17,625	177,800	118	18.00
20.00	16.00	MEDICAL RECORDS & LIBRARY	2,250	0	2,250	177,800	1	20.00
200.00			7,065,650	6,592,863	472,787		1,336	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	14,617	731	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	34.10	NICU	0	0	0	0	0	3.00
4.00	40.00	SUBPROVIDER - IPF	2,992	150	0	0	0	4.00
5.00	50.00	OPERATING ROOM	0	0	0	0	0	5.00
6.00	31.00	INTENSIVE CARE UNIT	11,967	598	0	0	0	6.00
7.00	53.00	ANESTHESIOLOGY	0	0	0	0	0	7.00
8.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	8.00
9.00	55.00	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	9.00
10.00	59.00	CARDIAC CATHETERIZATION	86	4	0	0	0	10.00
11.00	60.00	LABORATORY	0	0	0	0	0	11.00
12.00	65.00	RESPIRATORY THERAPY	11,284	564	0	0	0	12.00
13.00	69.00	ELECTROCARDIOLOGY	32,312	1,616	0	0	0	13.00
14.00	74.00	RENAL DIALYSIS	7,437	372	0	0	0	14.00
15.00	90.02	CARE STATIONS	20,344	1,017	0	0	0	15.00
16.00	91.00	EMERGENCY	0	0	0	0	0	16.00
17.00	93.00	OUTPATIENT REHAB	2,992	150	0	0	0	17.00
18.00	93.10	WOUND CARE CENTER	10,087	504	0	0	0	18.00
20.00	16.00	MEDICAL RECORDS & LIBRARY	86	4	0	0	0	20.00
200.00			114,204	5,710	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	14,617	132,627	2,045,140		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	543,197		2.00
3.00	34.10	NICU	0	0	0	998,716		3.00
4.00	40.00	SUBPROVIDER - IPF	0	2,992	20,191	20,191		4.00
5.00	50.00	OPERATING ROOM	0	0	0	398,980		5.00
6.00	31.00	INTENSIVE CARE UNIT	0	11,967	13,233	13,233		6.00
7.00	53.00	ANESTHESIOLOGY	0	0	0	1,804,866		7.00
8.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	34,548		8.00
9.00	55.00	RADIOLOGY-THERAPEUTIC	0	0	0	0		9.00
10.00	59.00	CARDIAC CATHETERIZATION	0	86	129,248	129,248		10.00
11.00	60.00	LABORATORY	0	0	0	18,179		11.00
12.00	65.00	RESPIRATORY THERAPY	0	11,284	13,506	13,506		12.00
13.00	69.00	ELECTROCARDIOLOGY	0	32,312	17,836	17,836		13.00
14.00	74.00	RENAL DIALYSIS	0	7,437	4,953	4,953		14.00
15.00	90.02	CARE STATIONS	0	20,344	11,656	409,353		15.00
16.00	91.00	EMERGENCY	0	0	0	484,167		16.00
17.00	93.00	OUTPATIENT REHAB	0	2,992	5,631	5,631		17.00
18.00	93.10	WOUND CARE CENTER	0	10,087	7,538	7,538		18.00
20.00	16.00	MEDICAL RECORDS & LIBRARY	0	86	2,164	2,164		20.00
200.00			0	114,204	358,583	6,951,446		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0179

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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	5,462,582	5,462,582			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	3,628,293		3,628,293		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,712,580	3,918	3,492	1,719,990	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	26,069,646	443,209	980,332	251,951	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	4,731,633	579,627	117,478	60,590	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	277,808	93,620	1,123	5,090	8.00
9.00	00900	HOUSEKEEPING	1,776,032	38,139	17,413	69,807	9.00
10.00	01000	DIETARY	864,162	117,849	2,181	20,881	10.00
11.00	01100	CAFETERIA	359,511	81,659	1,717	18,213	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	1,769,992	11,218	502,360	30,483	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-461,839	0	0	0	14.00
15.00	01500	PHARMACY	2,527,084	45,542	60,988	38,323	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,491,861	87,124	2,912	61,900	16.00
17.00	01700	SOCIAL SERVICE	681,868	6,578	0	12,094	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	62,233	17,837	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	16,556,864	1,231,513	138,366	370,263	30.00
31.00	03100	INTENSIVE CARE UNIT	3,094,668	128,882	39,400	53,257	31.00
34.10	02060	NICU	929,248	178,372	17,373	14,723	34.10
40.00	04000	SUBPROVIDER - IPF	878,971	142,182	7,543	16,842	40.00
43.00	04300	NURSERY	461,605	13,837	0	8,577	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	5,126,406	350,352	376,160	78,529	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,776,256	165,690	75,462	33,967	52.00
53.00	05300	ANESTHESIOLOGY	287,792	4,691	63,624	2,212	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,699,125	378,953	397,929	46,105	54.00
54.01	03440	BREAST HEALTH CENTER	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	1,590,638	359,013	26,744	12,331	55.00
56.00	05600	RADIOISOTOPE	891,585	34,602	2,819	7,033	56.00
56.10	03630	ULTRASOUND	901,811	24,127	45,864	15,494	56.10
57.00	05700	CT SCAN	908,564	16,218	198	13,811	57.00
58.00	05800	MRI	562,267	17,280	16,359	9,215	58.00
59.00	05900	CARDIAC CATHETERIZATION	901,027	87,227	116,158	18,553	59.00
60.00	06000	LABORATORY	6,286,818	127,644	77,107	76,849	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,746,811	24,951	61,764	36,863	65.00
65.01	03952	SLEEP LAB	169,012	27,426	11,823	4,056	65.01
66.00	06600	PHYSICAL THERAPY	1,388,589	71,452	8,474	27,481	66.00
68.00	06800	SPEECH PATHOLOGY	236,561	2,320	906	3,912	68.00
69.00	06900	ELECTROCARDIOLOGY	1,246,069	16,693	45,995	23,318	69.00
69.01	06901	C-PORT	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	124,397	16,084	5,644	2,189	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	4,707,075	38,891	19,526	9,761	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,062,450	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	9,191,227	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	735,048	16,909	17,536	10,311	74.00
75.10	03340	GI LAB	1,298,749	79,494	195,064	19,114	75.10
76.00	03951	ENTEROSTOMAL THERAPY	0	0	0	0	76.00
76.10	03950	NEUROLOGY	0	0	0	0	76.10
76.20	03290	EMG	0	0	0	0	76.20
76.30	03953	OS SVCS	15,336	0	0	0	76.30
76.40	03040	AUDIOLOGY	0	0	0	0	76.40
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	503,642	21,755	5,791	10,691	90.00
90.01	09001	PALOS DIAGNOSTIC CENTER	131,669	0	7,864	3,008	90.01
90.02	09002	CARE STATIONS	1,468,358	0	16,556	27,948	90.02
90.03	09003	OUTPATIENT CARE CENTER	1,834,107	0	58,363	33,801	90.03
91.00	09100	EMERGENCY	5,173,700	152,699	43,622	98,587	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00

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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	
93.00	04951	OUTPATIENT REHAB	800,473	112,488	390	16,935	930,286	93.00
93.10	04950	WOUND CARE CENTER	573,595	17,219	3,686	8,336	602,836	93.10
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	1,397,527	0	17,295	17,974	1,432,796	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	862,335	0	15,032	12,674	890,041	116.00
117.00	06950	MOBILE MED	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	133,473,821	5,385,284	3,626,433	1,714,052	133,388,725	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	10,929	0	0	10,929	190.00
191.10	19101	ADULT DAY CARE	0	0	0	0	0	191.10
192.00	19200	PHYSICIANS' PRIVATE OFFICES	467,544	18,868	1,860	5,938	494,210	192.00
192.01	19201	VACANT SPACE	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	19,487	0	0	19,487	193.00
194.00	07950	FUND DEVELOPMENT	0	28,014	0	0	28,014	194.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	133,941,365	5,462,582	3,628,293	1,719,990	133,941,365	202.00

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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	27,745,138					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	1,427,950	0	6,917,278			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	98,237	0	145,991	621,869		8.00
9.00	00900	HOUSEKEEPING	494,613	0	59,474	7,637	2,463,115	9.00
10.00	01000	DIETARY	261,452	0	183,776	0	67,442	10.00
11.00	01100	CAFETERIA	119,947	0	127,341	0	46,732	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	601,959	0	17,493	0	6,420	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	695,056	0	71,018	94	26,062	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	947,868	0	135,862	0	49,859	16.00
17.00	01700	SOCIAL SERVICE	182,233	0	10,258	0	3,764	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	20,829	0	27,816	0	10,208	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	4,759,600	0	1,920,430	159,238	704,763	30.00
31.00	03100	INTENSIVE CARE UNIT	862,652	0	200,979	17,198	73,756	31.00
34.10	02060	NICU	296,477	0	278,156	3,301	102,078	34.10
40.00	04000	SUBPROVIDER - IPF	271,978	0	221,721	2,732	81,367	40.00
43.00	04300	NURSERY	125,909	0	21,577	0	7,918	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	1,542,959	0	546,343	233,619	200,498	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	533,628	0	258,379	43,924	94,821	52.00
53.00	05300	ANESTHESIOLOGY	93,210	0	7,316	0	2,685	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	916,214	0	590,944	28,960	216,866	54.00
54.01	03440	BREAST HEALTH CENTER	0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	517,331	0	559,848	2,302	205,454	55.00
56.00	05600	RADIOISOTOPE	243,494	0	53,959	4,118	19,802	56.00
56.10	03630	ULTRASOUND	256,827	0	37,623	8,356	13,807	56.10
57.00	05700	CT SCAN	244,210	0	25,291	10,109	9,281	57.00
58.00	05800	MRI	157,411	0	26,947	2,129	9,889	58.00
59.00	05900	CARDIAC CATHETERIZATION	292,119	0	136,023	1,673	49,918	59.00
60.00	06000	LABORATORY	1,708,656	0	199,050	1,936	73,048	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	486,548	0	38,910	5	14,279	65.00
65.01	03952	SLEEP LAB	55,230	0	42,768	679	15,695	65.01
66.00	06600	PHYSICAL THERAPY	389,156	0	111,423	8,506	40,890	66.00
68.00	06800	SPEECH PATHOLOGY	63,394	0	3,618	0	1,328	68.00
69.00	06900	ELECTROCARDIOLOGY	346,515	0	26,031	2,396	9,553	69.00
69.01	06901	C-PORT	0	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	38,581	0	25,082	512	9,205	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,242,196	0	60,648	0	22,257	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	796,641	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,390,932	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	202,852	0	26,369	3,137	9,677	74.00
75.10	03340	GI LAB	414,240	0	123,964	6,152	45,493	75.10
76.00	03951	ENTEROSTOMAL THERAPY	0	0	0	0	0	76.00
76.10	03950	NEUROLOGY	0	0	0	0	0	76.10
76.20	03290	EMG	0	0	0	0	0	76.20
76.30	03953	OS SVCS	3,989	0	0	0	0	76.30
76.40	03040	AUDIOLOGY	0	0	0	0	0	76.40
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	140,960	0	33,925	563	12,450	90.00
90.01	09001	PALOS DIAGNOSTIC CENTER	37,079	0	0	0	0	90.01
90.02	09002	CARE STATIONS	393,544	0	0	1,970	0	90.02
90.03	09003	OUTPATIENT CARE CENTER	501,085	0	0	5,433	0	90.03
91.00	09100	EMERGENCY	1,422,560	0	238,120	63,266	87,386	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04951	OUTPATIENT REHAB	241,997	0	175,415	0	64,374	93.00
93.10	04950	WOUND CARE CENTER	156,817	0	26,851	1,924	9,854	93.10
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20

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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	
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
101.00	10100	HOME HEALTH AGENCY	372,716	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	231,528	0	0	0	0	116.00
117.00	06950	MOBILE MED	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	27,601,379	0	6,796,739	621,869	2,418,879	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,843	0	17,043	0	6,254	190.00
191.10	19101	ADULT DAY CARE	0	0	0	0	0	191.10
192.00	19200	PHYSICIANS' PRIVATE OFFICES	128,560	0	29,423	0	10,798	192.00
192.01	19201	VACANT SPACE	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	5,069	0	30,388	0	11,152	193.00
194.00	07950	FUND DEVELOPMENT	7,287	0	43,685	0	16,032	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)	27,745,138	0	6,917,278	621,869	2,463,115	202.00

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Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	1,517,743					10.00
11.00	01100	CAFETERIA	0	755,120				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	32,230	0	2,972,155		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	-461,839	14.00
15.00	01500	PHARMACY	0	23,922	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	38,639	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	7,549	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	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	1,330,802	231,126	0	1,275,386	0	30.00
31.00	03100	INTENSIVE CARE UNIT	128,694	33,244	0	183,444	0	31.00
34.10	02060	NICU	0	9,190	0	50,713	0	34.10
40.00	04000	SUBPROVIDER - IPF	58,247	10,513	0	58,012	0	40.00
43.00	04300	NURSERY	0	5,354	0	29,544	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	49,019	0	270,493	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	21,202	0	116,998	0	52.00
53.00	05300	ANESTHESIOLOGY	0	1,381	0	7,620	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	28,779	0	158,809	0	54.00
54.01	03440	BREAST HEALTH CENTER	0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	7,697	0	42,475	0	55.00
56.00	05600	RADIOISOTOPE	0	4,390	0	24,226	0	56.00
56.10	03630	ULTRASOUND	0	9,671	0	0	0	56.10
57.00	05700	CT SCAN	0	8,621	0	0	0	57.00
58.00	05800	MRI	0	5,752	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	6,247	0	0	0	59.00
60.00	06000	LABORATORY	0	47,970	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	23,011	0	126,976	0	65.00
65.01	03952	SLEEP LAB	0	2,532	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	17,154	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	2,442	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	14,555	0	0	0	69.00
69.01	06901	C-PORT	0	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,367	0	7,541	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	6,093	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	6,436	0	0	0	74.00
75.10	03340	GI LAB	0	11,931	0	65,838	0	75.10
76.00	03951	ENTEROSTOMAL THERAPY	0	0	0	0	0	76.00
76.10	03950	NEUROLOGY	0	0	0	0	0	76.10
76.20	03290	EMG	0	0	0	0	0	76.20
76.30	03953	OS SVCS	0	0	0	0	0	76.30
76.40	03040	AUDIOLOGY	0	0	0	0	0	76.40
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	6,674	0	36,827	0	90.00
90.01	09001	PALOS DIAGNOSTIC CENTER	0	0	0	0	0	90.01
90.02	09002	CARE STATIONS	0	0	0	0	0	90.02
90.03	09003	OUTPATIENT CARE CENTER	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	61,539	0	339,585	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
93.00	04951	OUTPATIENT REHAB	0	10,571	0	58,332	0	93.00
93.10	04950	WOUND CARE CENTER	0	5,203	0	28,713	0	93.10
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10

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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	
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
101.00	10100	HOME HEALTH AGENCY	0	0	0	61,910	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	28,713	0	116.00
117.00	06950	MOBILE MED	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,517,743	752,004	0	2,972,155	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.10	19101	ADULT DAY CARE	0	0	0	0	0	191.10
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	3,116	0	0	0	192.00
192.01	19201	VACANT SPACE	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	FUND DEVELOPMENT	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	-461,839	201.00
202.00		TOTAL (sum lines 118 through 201)	1,517,743	755,120	0	2,972,155	-461,839	202.00

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Cost Center Description			PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
			15.00	16.00	17.00	19.00	20.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	3,488,089					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	4,816,025				16.00
17.00	01700	SOCIAL SERVICE	0	0	904,344			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	1,895	610,992	553,873	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	1,567	77,671	53,525	0	0	31.00
34.10	02060	NICU	22	28,679	17,177	0	0	34.10
40.00	04000	SUBPROVIDER - IPF	15	21,434	24,226	0	0	40.00
43.00	04300	NURSERY	0	16,482	210,330	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,685	218,258	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	71	46,425	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	8,550	80,667	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	53,256	222,055	0	0	0	54.00
54.01	03440	BREAST HEALTH CENTER	0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	1,297	74,856	0	0	0	55.00
56.00	05600	RADIOISOTOPE	72,299	58,594	0	0	0	56.00
56.10	03630	ULTRASOUND	90	92,320	0	0	0	56.10
57.00	05700	CT SCAN	13,376	451,359	0	0	0	57.00
58.00	05800	MRI	8,605	58,886	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	8,020	102,983	0	0	0	59.00
60.00	06000	LABORATORY	19	716,117	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	208	163,999	0	0	0	65.00
65.01	03952	SLEEP LAB	0	9,012	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	50,940	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	11,618	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,846	93,742	0	0	0	69.00
69.01	06901	C-PORT	0	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	8,951	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	107,581	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	83,066	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,292,736	626,215	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	27,345	0	0	0	74.00
75.10	03340	GI LAB	180	96,318	0	0	0	75.10
76.00	03951	ENTEROSTOMAL THERAPY	0	0	0	0	0	76.00
76.10	03950	NEUROLOGY	0	0	0	0	0	76.10
76.20	03290	EMG	0	0	0	0	0	76.20
76.30	03953	OS SVCS	0	131	0	0	0	76.30
76.40	03040	AUDIOLOGY	0	0	0	0	0	76.40
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	2,304	7,542	0	0	0	90.00
90.01	09001	PALOS DIAGNOSTIC CENTER	0	2,958	0	0	0	90.01
90.02	09002	CARE STATIONS	8,171	27,496	0	0	0	90.02
90.03	09003	OUTPATIENT CARE CENTER	5,761	92,315	0	0	0	90.03
91.00	09100	EMERGENCY	1,192	473,496	45,213	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04951	OUTPATIENT REHAB	156	21,352	0	0	0	93.00
93.10	04950	WOUND CARE CENTER	1,509	16,791	0	0	0	93.10
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10

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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	
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
101.00	10100	HOME HEALTH AGENCY	11	11,713	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	2,248	5,666	0		0	116.00
117.00	06950	MOBILE MED	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	3,488,089	4,816,025	904,344	0		118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.10	19101	ADULT DAY CARE	0	0	0	0	0	191.10
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	VACANT SPACE	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	FUND DEVELOPMENT	0	0	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)	3,488,089	4,816,025	904,344	0		202.00

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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		138,923				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)			0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	138,923	0	29,984,034	-138,923	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	4,948,937	0	31.00
34.10	02060	NICU	0	0	0	1,925,509	0	34.10
40.00	04000	SUBPROVIDER - IPF	0	0	0	1,795,783	0	40.00
43.00	04300	NURSERY	0	0	0	901,133	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	8,995,321	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	3,166,823	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	559,748	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	5,737,995	0	54.00
54.01	03440	BREAST HEALTH CENTER	0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	3,399,986	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	1,416,921	0	56.00
56.10	03630	ULTRASOUND	0	0	0	1,405,990	0	56.10
57.00	05700	CT SCAN	0	0	0	1,701,038	0	57.00
58.00	05800	MRI	0	0	0	874,740	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	1,719,948	0	59.00
60.00	06000	LABORATORY	0	0	0	9,315,214	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	2,724,325	0	65.00
65.01	03952	SLEEP LAB	0	0	0	338,233	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	2,114,065	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	326,099	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	1,826,713	0	69.00
69.01	06901	C-PORT	0	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	239,553	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	6,214,028	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3,942,157	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	15,501,110	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	1,055,620	0	74.00
75.10	03340	GI LAB	0	0	0	2,356,537	0	75.10
76.00	03951	ENTEROSTOMAL THERAPY	0	0	0	0	0	76.00
76.10	03950	NEUROLOGY	0	0	0	0	0	76.10
76.20	03290	EMG	0	0	0	0	0	76.20
76.30	03953	OS SVCS	0	0	0	19,456	0	76.30
76.40	03040	AUDIOLOGY	0	0	0	0	0	76.40
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	783,124	0	90.00
90.01	09001	PALOS DIAGNOSTIC CENTER	0	0	0	182,578	0	90.01
90.02	09002	CARE STATIONS	0	0	0	1,944,043	0	90.02
90.03	09003	OUTPATIENT CARE CENTER	0	0	0	2,530,865	0	90.03
91.00	09100	EMERGENCY	0	0	0	8,200,965	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00

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			SERVICES-SALAR Y & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV				
			21.00	22.00		24.00	25.00	
93.00	04951	OUTPATIENT REHAB	0	0	0	1,502,483	0	93.00
93.10	04950	WOUND CARE CENTER	0	0	0	850,498	0	93.10
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	0	0	0	1,879,146	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE			0	1,158,196	0	116.00
117.00	06950	MOBILE MED	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	138,923	0	133,538,914	-138,923	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	37,069	0	190.00
191.10	19101	ADULT DAY CARE	0	0	0	0	0	191.10
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	666,107	0	192.00
192.01	19201	VACANT SPACE	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	66,096	0	193.00
194.00	07950	FUND DEVELOPMENT	0	0	0	95,018	0	194.00
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	-461,839	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	138,923	0	133,941,365	-138,923	202.00

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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
34.10	02060	NICU	34.10
40.00	04000	SUBPROVIDER - IPF	40.00
43.00	04300	NURSERY	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
54.01	03440	BREAST HEALTH CENTER	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	55.00
56.00	05600	RADIOISOTOPE	56.00
56.10	03630	ULTRASOUND	56.10
57.00	05700	CT SCAN	57.00
58.00	05800	MRI	58.00
59.00	05900	CARDIAC CATHETERIZATION	59.00
60.00	06000	LABORATORY	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	62.30
65.00	06500	RESPIRATORY THERAPY	65.00
65.01	03952	SLEEP LAB	65.01
66.00	06600	PHYSICAL THERAPY	66.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
69.01	06901	C-PORT	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
74.00	07400	RENAL DIALYSIS	74.00
75.10	03340	GI LAB	75.10
76.00	03951	ENTEROSTOMAL THERAPY	76.00
76.10	03950	NEUROLOGY	76.10
76.20	03290	EMG	76.20
76.30	03953	OS SVCS	76.30
76.40	03040	AUDIOLOGY	76.40
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	PALOS DIAGNOSTIC CENTER	90.01
90.02	09002	CARE STATIONS	90.02
90.03	09003	OUTPATIENT CARE CENTER	90.03
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
93.00	04951	OUTPATIENT REHAB	93.00
93.10	04950	WOUND CARE CENTER	93.10
OTHER REIMBURSABLE COST CENTERS			
99.10	09910	CORF	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	99.30

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0179

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Cost Center Description			Total	
			26.00	
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	99.40
101.00	10100	HOME HEALTH AGENCY	1,879,146	101.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
116.00	11600	HOSPICE	1,158,196	116.00
117.00	06950	MOBILE MED	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	133,399,991	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	37,069	190.00
191.10	19101	ADULT DAY CARE	0	191.10
192.00	19200	PHYSICIANS' PRIVATE OFFICES	666,107	192.00
192.01	19201	VACANT SPACE	0	192.01
193.00	19300	NONPAID WORKERS	66,096	193.00
194.00	07950	FUND DEVELOPMENT	95,018	194.00
200.00		Cross Foot Adjustments	0	200.00
201.00		Negative Cost Centers	-461,839	201.00
202.00		TOTAL (sum lines 118 through 201)	133,802,442	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0179

Period:
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Cost Center Description			CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		
			0	1.00	2.00	2A	4.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	432	3,918	3,492	7,842	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	105,982	443,209	980,332	1,529,523	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	3,257	579,627	117,478	700,362	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	93,620	1,123	94,743	8.00
9.00	00900	HOUSEKEEPING	26,443	38,139	17,413	81,995	9.00
10.00	01000	DIETARY	1,346	117,849	2,181	121,376	95 10.00
11.00	01100	CAFETERIA	504	81,659	1,717	83,880	83 11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	761	11,218	502,360	514,339	139 13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	14.00
15.00	01500	PHARMACY	14,766	45,542	60,988	121,296	175 15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	108	87,124	2,912	90,144	282 16.00
17.00	01700	SOCIAL SERVICE	0	6,578	0	6,578	55 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	17,837	0	17,837	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	1,704	1,231,513	138,366	1,371,583	1,689 30.00
31.00	03100	INTENSIVE CARE UNIT	941	128,882	39,400	169,223	243 31.00
34.10	02060	NICU	0	178,372	17,373	195,745	67 34.10
40.00	04000	SUBPROVIDER - IPF	108	142,182	7,543	149,833	77 40.00
43.00	04300	NURSERY	0	13,837	0	13,837	39 43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	6,895	350,352	376,160	733,407	358 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,374	165,690	75,462	242,526	155 52.00
53.00	05300	ANESTHESIOLOGY	216	4,691	63,624	68,531	10 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,793	378,953	397,929	778,675	210 54.00
54.01	03440	BREAST HEALTH CENTER	0	0	0	0	0 54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	840	359,013	26,744	386,597	56 55.00
56.00	05600	RADIOISOTOPE	477	34,602	2,819	37,898	32 56.00
56.10	03630	ULTRASOUND	108	24,127	45,864	70,099	71 56.10
57.00	05700	CT SCAN	0	16,218	198	16,416	63 57.00
58.00	05800	MRI	442	17,280	16,359	34,081	42 58.00
59.00	05900	CARDIAC CATHETERIZATION	3,228	87,227	116,158	206,613	85 59.00
60.00	06000	LABORATORY	702	127,644	77,107	205,453	350 60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0 62.30
65.00	06500	RESPIRATORY THERAPY	27,801	24,951	61,764	114,516	168 65.00
65.01	03952	SLEEP LAB	68	27,426	11,823	39,317	18 65.01
66.00	06600	PHYSICAL THERAPY	1,188	71,452	8,474	81,114	125 66.00
68.00	06800	SPEECH PATHOLOGY	14,748	2,320	906	17,974	18 68.00
69.00	06900	ELECTROCARDIOLOGY	1,149	16,693	45,995	63,837	106 69.00
69.01	06901	C-PORT	0	0	0	0	0 69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	16,084	5,644	21,728	10 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	55,822	38,891	19,526	114,239	45 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0 73.00
74.00	07400	RENAL DIALYSIS	864	16,909	17,536	35,309	47 74.00
75.10	03340	GI LAB	324	79,494	195,064	274,882	87 75.10
76.00	03951	ENTEROSTOMAL THERAPY	0	0	0	0	0 76.00
76.10	03950	NEUROLOGY	0	0	0	0	0 76.10
76.20	03290	EMG	0	0	0	0	0 76.20
76.30	03953	OS SVCS	0	0	0	0	0 76.30
76.40	03040	AUDIOLOGY	0	0	0	0	0 76.40
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	216	21,755	5,791	27,762	49 90.00
90.01	09001	PALOS DIAGNOSTIC CENTER	28,812	0	7,864	36,676	14 90.01
90.02	09002	CARE STATIONS	185,980	0	16,556	202,536	127 90.02
90.03	09003	OUTPATIENT CARE CENTER	167,262	0	58,363	225,625	154 90.03
91.00	09100	EMERGENCY	540	152,699	43,622	196,861	450 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0	92.00
93.00	04951	OUTPATIENT REHAB	320	112,488	390	113,198	77 93.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	2A	4.00	
93.10	04950	WOUND CARE CENTER	276	17,219	3,686	21,181	38	93.10
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	0	0	17,295	17,295	82	101.00
		SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	15,032	15,032	58	116.00
117.00	06950	MOBILE MED	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	657,797	5,385,284	3,626,433	9,669,514	7,815	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	10,929	0	10,929	0	190.00
191.10	19101	ADULT DAY CARE	0	0	0	0	0	191.10
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	18,868	1,860	20,728	27	192.00
192.01	19201	VACANT SPACE	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	19,487	0	19,487	0	193.00
194.00	07950	FUND DEVELOPMENT	0	28,014	0	28,014	0	194.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	657,797	5,462,582	3,628,293	9,748,672	7,842	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0179

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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	1,530,672					5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700	OPERATION OF PLANT	78,777	0	779,415			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	5,420	0	16,450	116,636		8.00
9.00	00900	HOUSEKEEPING	27,287	0	6,701	1,432	117,733	9.00
10.00	01000	DIETARY	14,424	0	20,707	0	3,224	10.00
11.00	01100	CAFETERIA	6,617	0	14,348	0	2,234	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	33,209	0	1,971	0	307	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	38,345	0	8,002	18	1,246	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	52,292	0	15,308	0	2,383	16.00
17.00	01700	SOCIAL SERVICE	10,053	0	1,156	0	180	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	1,149	0	3,134	0	488	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	262,602	0	216,389	29,866	33,687	30.00
31.00	03100	INTENSIVE CARE UNIT	47,591	0	22,646	3,226	3,525	31.00
34.10	02060	NICU	16,356	0	31,342	619	4,879	34.10
40.00	04000	SUBPROVIDER - IPF	15,005	0	24,983	512	3,889	40.00
43.00	04300	NURSERY	6,946	0	2,431	0	378	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	85,122	0	61,560	43,818	9,583	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	29,439	0	29,113	8,238	4,532	52.00
53.00	05300	ANESTHESIOLOGY	5,142	0	824	0	128	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	50,546	0	66,585	5,432	10,366	54.00
54.01	03440	BREAST HEALTH CENTER	0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	28,540	0	63,082	432	9,820	55.00
56.00	05600	RADIOISOTOPE	13,433	0	6,080	772	947	56.00
56.10	03630	ULTRASOUND	14,169	0	4,239	1,567	660	56.10
57.00	05700	CT SCAN	13,473	0	2,850	1,896	444	57.00
58.00	05800	MRI	8,684	0	3,036	399	473	58.00
59.00	05900	CARDIAC CATHETERIZATION	16,116	0	15,327	314	2,386	59.00
60.00	06000	LABORATORY	94,263	0	22,428	363	3,492	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	26,842	0	4,384	1	683	65.00
65.01	03952	SLEEP LAB	3,047	0	4,819	127	750	65.01
66.00	06600	PHYSICAL THERAPY	21,469	0	12,555	1,595	1,954	66.00
68.00	06800	SPEECH PATHOLOGY	3,497	0	408	0	63	68.00
69.00	06900	ELECTROCARDIOLOGY	19,117	0	2,933	449	457	69.00
69.01	06901	C-PORT	0	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	2,128	0	2,826	96	440	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	68,530	0	6,834	0	1,064	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	43,949	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	131,903	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	11,191	0	2,971	588	463	74.00
75.10	03340	GI LAB	22,853	0	13,968	1,154	2,174	75.10
76.00	03951	ENTEROSTOMAL THERAPY	0	0	0	0	0	76.00
76.10	03950	NEUROLOGY	0	0	0	0	0	76.10
76.20	03290	EMG	0	0	0	0	0	76.20
76.30	03953	OS SVCS	220	0	0	0	0	76.30
76.40	03040	AUDIOLOGY	0	0	0	0	0	76.40
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	7,777	0	3,823	106	595	90.00
90.01	09001	PALOS DIAGNOSTIC CENTER	2,046	0	0	0	0	90.01
90.02	09002	CARE STATIONS	21,711	0	0	370	0	90.02
90.03	09003	OUTPATIENT CARE CENTER	27,644	0	0	1,019	0	90.03
91.00	09100	EMERGENCY	78,480	0	26,831	11,866	4,177	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04951	OUTPATIENT REHAB	13,351	0	19,765	0	3,077	93.00
93.10	04950	WOUND CARE CENTER	8,651	0	3,025	361	471	93.10
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0179

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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	
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
101.00	10100	HOME HEALTH AGENCY	20,562	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	12,773	0	0	0	0	116.00
117.00	06950	MOBILE MED	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,522,741	0	765,834	116,636	115,619	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	157	0	1,920	0	299	190.00
191.10	19101	ADULT DAY CARE	0	0	0	0	0	191.10
192.00	19200	PHYSICIANS' PRIVATE OFFICES	7,092	0	3,315	0	516	192.00
192.01	19201	VACANT SPACE	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	280	0	3,424	0	533	193.00
194.00	07950	FUND DEVELOPMENT	402	0	4,922	0	766	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)	1,530,672	0	779,415	116,636	117,733	202.00

ALLOCATION OF CAPITAL RELATED COSTS

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Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
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	159,826					10.00
11.00	01100	CAFETERIA	0	107,162				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	4,574	0	554,539		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	3,395	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	5,483	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	1,071	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	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	140,140	32,802	0	237,959	0	30.00
31.00	03100	INTENSIVE CARE UNIT	13,552	4,718	0	34,227	0	31.00
34.10	02060	NICU	0	1,304	0	9,462	0	34.10
40.00	04000	SUBPROVIDER - IPF	6,134	1,492	0	10,824	0	40.00
43.00	04300	NURSERY	0	760	0	5,512	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	6,956	0	50,468	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	3,009	0	21,829	0	52.00
53.00	05300	ANESTHESIOLOGY	0	196	0	1,422	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	4,084	0	29,630	0	54.00
54.01	03440	BREAST HEALTH CENTER	0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	1,092	0	7,925	0	55.00
56.00	05600	RADIOISOTOPE	0	623	0	4,520	0	56.00
56.10	03630	ULTRASOUND	0	1,372	0	0	0	56.10
57.00	05700	CT SCAN	0	1,223	0	0	0	57.00
58.00	05800	MRI	0	816	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	887	0	0	0	59.00
60.00	06000	LABORATORY	0	6,808	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	3,266	0	23,691	0	65.00
65.01	03952	SLEEP LAB	0	359	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	2,434	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	347	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,066	0	0	0	69.00
69.01	06901	C-PORT	0	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	194	0	1,407	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	865	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	913	0	0	0	74.00
75.10	03340	GI LAB	0	1,693	0	12,284	0	75.10
76.00	03951	ENTEROSTOMAL THERAPY	0	0	0	0	0	76.00
76.10	03950	NEUROLOGY	0	0	0	0	0	76.10
76.20	03290	EMG	0	0	0	0	0	76.20
76.30	03953	OS SVCS	0	0	0	0	0	76.30
76.40	03040	AUDIOLOGY	0	0	0	0	0	76.40
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	947	0	6,871	0	90.00
90.01	09001	PALOS DIAGNOSTIC CENTER	0	0	0	0	0	90.01
90.02	09002	CARE STATIONS	0	0	0	0	0	90.02
90.03	09003	OUTPATIENT CARE CENTER	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	8,733	0	63,359	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
93.00	04951	OUTPATIENT REHAB	0	1,500	0	10,884	0	93.00
93.10	04950	WOUND CARE CENTER	0	738	0	5,357	0	93.10
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0179

Period:
From 07/01/2019
To 01/31/2020Worksheet B
Part II
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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	
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
101.00	10100	HOME HEALTH AGENCY	0	0	0	11,551	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	0	5,357	0	116.00
117.00	06950	MOBILE MED	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	159,826	106,720	0	554,539	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.10	19101	ADULT DAY CARE	0	0	0	0	0	191.10
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	442	0	0	0	192.00
192.01	19201	VACANT SPACE	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	FUND DEVELOPMENT	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)	159,826	107,162	0	554,539	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0179

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	172,477					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	165,892				16.00
17.00	01700	SOCIAL SERVICE	0	0	19,093			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	94	21,010	11,693			30.00
31.00	03100	INTENSIVE CARE UNIT	77	2,671	1,130			31.00
34.10	02060	NICU	1	986	363			34.10
40.00	04000	SUBPROVIDER - IPF	1	737	511			40.00
43.00	04300	NURSERY	0	567	4,441			43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	133	7,505	0			50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4	1,596	0			52.00
53.00	05300	ANESTHESIOLOGY	423	2,774	0			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,633	7,636	0			54.00
54.01	03440	BREAST HEALTH CENTER	0	0	0			54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	64	2,574	0			55.00
56.00	05600	RADIOISOTOPE	3,575	2,015	0			56.00
56.10	03630	ULTRASOUND	4	3,175	0			56.10
57.00	05700	CT SCAN	661	15,521	0			57.00
58.00	05800	MRI	425	2,025	0			58.00
59.00	05900	CARDIAC CATHETERIZATION	397	3,541	0			59.00
60.00	06000	LABORATORY	1	24,909	0			60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0			62.30
65.00	06500	RESPIRATORY THERAPY	10	5,639	0			65.00
65.01	03952	SLEEP LAB	0	310	0			65.01
66.00	06600	PHYSICAL THERAPY	0	1,752	0			66.00
68.00	06800	SPEECH PATHOLOGY	0	399	0			68.00
69.00	06900	ELECTROCARDIOLOGY	91	3,224	0			69.00
69.01	06901	C-PORT	0	0	0			69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	308	0			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	3,699	0			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	2,856	0			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	162,817	21,534	0			73.00
74.00	07400	RENAL DIALYSIS	0	940	0			74.00
75.10	03340	GI LAB	9	3,312	0			75.10
76.00	03951	ENTEROSTOMAL THERAPY	0	0	0			76.00
76.10	03950	NEUROLOGY	0	0	0			76.10
76.20	03290	EMG	0	0	0			76.20
76.30	03953	OS SVCS	0	5	0			76.30
76.40	03040	AUDIOLOGY	0	0	0			76.40
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	114	259	0			90.00
90.01	09001	PALOS DIAGNOSTIC CENTER	0	102	0			90.01
90.02	09002	CARE STATIONS	404	946	0			90.02
90.03	09003	OUTPATIENT CARE CENTER	285	3,174	0			90.03
91.00	09100	EMERGENCY	59	16,282	955			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04951	OUTPATIENT REHAB	8	734	0			93.00
93.10	04950	WOUND CARE CENTER	75	577	0			93.10
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0			99.10

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0179

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To 01/31/2020Worksheet B
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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	
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
101.00	10100	HOME HEALTH AGENCY	1	403	0			101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	111	195	0			116.00
117.00	06950	MOBILE MED	0	0	0			117.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	172,477	165,892	19,093	0	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0			190.00
191.10	19101	ADULT DAY CARE	0	0	0			191.10
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0			192.00
192.01	19201	VACANT SPACE	0	0	0			192.01
193.00	19300	NONPAID WORKERS	0	0	0			193.00
194.00	07950	FUND DEVELOPMENT	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)	172,477	165,892	19,093	0	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0179

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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		22,608				22.00
23.00	02300	PARAMED ED PRGM- (SPECIFY)			0			23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS				2,359,514	0	30.00
31.00	03100	INTENSIVE CARE UNIT				302,829	0	31.00
34.10	02060	NICU				261,124	0	34.10
40.00	04000	SUBPROVIDER - IPF				213,998	0	40.00
43.00	04300	NURSERY				34,911	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM				998,910	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM				340,441	0	52.00
53.00	05300	ANESTHESIOLOGY				79,450	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC				955,797	0	54.00
54.01	03440	BREAST HEALTH CENTER				0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC				500,182	0	55.00
56.00	05600	RADIOISOTOPE				69,895	0	56.00
56.10	03630	ULTRASOUND				95,356	0	56.10
57.00	05700	CT SCAN				52,547	0	57.00
58.00	05800	MRI				49,981	0	58.00
59.00	05900	CARDIAC CATHETERIZATION				245,666	0	59.00
60.00	06000	LABORATORY				358,067	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS				0	0	62.30
65.00	06500	RESPIRATORY THERAPY				179,200	0	65.00
65.01	03952	SLEEP LAB				48,747	0	65.01
66.00	06600	PHYSICAL THERAPY				122,998	0	66.00
68.00	06800	SPEECH PATHOLOGY				22,706	0	68.00
69.00	06900	ELECTROCARDIOLOGY				92,280	0	69.00
69.01	06901	C-PORT				0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY				29,137	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT				195,276	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS				46,805	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS				316,254	0	73.00
74.00	07400	RENAL DIALYSIS				52,422	0	74.00
75.10	03340	GI LAB				332,416	0	75.10
76.00	03951	ENTEROSTOMAL THERAPY				0	0	76.00
76.10	03950	NEUROLOGY				0	0	76.10
76.20	03290	EMG				0	0	76.20
76.30	03953	OS SVCS				225	0	76.30
76.40	03040	AUDIOLOGY				0	0	76.40
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				48,303	0	90.00
90.01	09001	PALOS DIAGNOSTIC CENTER				38,838	0	90.01
90.02	09002	CARE STATIONS				226,094	0	90.02
90.03	09003	OUTPATIENT CARE CENTER				257,901	0	90.03
91.00	09100	EMERGENCY				408,053	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00

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	23.00	24.00	25.00	
93.00	04951	OUTPATIENT REHAB				162,594	0	93.00
93.10	04950	WOUND CARE CENTER				40,474	0	93.10
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF				0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY				0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY				0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY				0	0	99.40
101.00	10100	HOME HEALTH AGENCY				49,894	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE				33,526	0	116.00
117.00	06950	MOBILE MED				0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	9,622,811	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN				13,305	0	190.00
191.10	19101	ADULT DAY CARE				0	0	191.10
192.00	19200	PHYSICIANS' PRIVATE OFFICES				32,120	0	192.00
192.01	19201	VACANT SPACE				0	0	192.01
193.00	19300	NONPAID WORKERS				23,724	0	193.00
194.00	07950	FUND DEVELOPMENT				34,104	0	194.00
200.00		Cross Foot Adjustments	0	22,608	0	22,608	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	22,608	0	9,748,672	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0179

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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
34.10	02060	NICU	34.10
40.00	04000	SUBPROVIDER - IPF	40.00
43.00	04300	NURSERY	43.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
54.01	03440	BREAST HEALTH CENTER	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	55.00
56.00	05600	RADIOISOTOPE	56.00
56.10	03630	ULTRASOUND	56.10
57.00	05700	CT SCAN	57.00
58.00	05800	MRI	58.00
59.00	05900	CARDIAC CATHETERIZATION	59.00
60.00	06000	LABORATORY	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	62.30
65.00	06500	RESPIRATORY THERAPY	65.00
65.01	03952	SLEEP LAB	65.01
66.00	06600	PHYSICAL THERAPY	66.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
69.01	06901	C-PORT	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
74.00	07400	RENAL DIALYSIS	74.00
75.10	03340	GI LAB	75.10
76.00	03951	ENTEROSTOMAL THERAPY	76.00
76.10	03950	NEUROLOGY	76.10
76.20	03290	EMG	76.20
76.30	03953	OS SVCS	76.30
76.40	03040	AUDIOLOGY	76.40
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	PALOS DIAGNOSTIC CENTER	90.01
90.02	09002	CARE STATIONS	90.02
90.03	09003	OUTPATIENT CARE CENTER	90.03
91.00	09100	EMERGENCY	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
93.00	04951	OUTPATIENT REHAB	93.00
93.10	04950	WOUND CARE CENTER	93.10
OTHER REIMBURSABLE COST CENTERS			
99.10	09910	CORF	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	99.30

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0179

Period:
From 07/01/2019
To 01/31/2020Worksheet B
Part II
Date/Time Prepared:
7/28/2020 8:27 am

Cost Center Description			Total	
			26.00	
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	99.40
101.00	10100	HOME HEALTH AGENCY	49,894	101.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
116.00	11600	HOSPICE	33,526	116.00
117.00	06950	MOBILE MED	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	9,622,811	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	13,305	190.00
191.10	19101	ADULT DAY CARE	0	191.10
192.00	19200	PHYSICIANS' PRIVATE OFFICES	32,120	192.00
192.01	19201	VACANT SPACE	0	192.01
193.00	19300	NONPAID WORKERS	23,724	193.00
194.00	07950	FUND DEVELOPMENT	34,104	194.00
200.00		Cross Foot Adjustments	22,608	200.00
201.00		Negative Cost Centers	0	201.00
202.00		TOTAL (sum lines 118 through 201)	9,748,672	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0179

Period:
From 07/01/2019
To 01/31/2020

Worksheet B-1

Date/Time Prepared:
7/28/2020 8:27 am

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (FTE'S SALARIES))	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
		BLDG & FIXT ((SQUARE FEET))	MVBLE EQUIP (DOLLAR VALUE)				
		1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT	529,806				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		3,640,114			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	380	3,503	1,811,617		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	42,986	983,528	265,373	-27,745,138	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00	00700	OPERATION OF PLANT	56,217	117,861	63,818	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	9,080	1,127	5,361	0	8.00
9.00	00900	HOUSEKEEPING	3,699	17,470	73,526	0	9.00
10.00	01000	DIETARY	11,430	2,188	21,993	0	10.00
11.00	01100	CAFETERIA	7,920	1,723	19,183	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	1,088	503,996	32,107	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	461,839	14.00
15.00	01500	PHARMACY	4,417	61,187	40,365	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	8,450	2,921	65,198	0	16.00
17.00	01700	SOCIAL SERVICE	638	0	12,738	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	1,730	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	119,442	138,817	389,989	0	30.00
31.00	03100	INTENSIVE CARE UNIT	12,500	39,528	56,094	0	31.00
34.10	02060	NICU	17,300	17,430	15,507	0	34.10
40.00	04000	SUBPROVIDER - IPF	13,790	7,568	17,739	0	40.00
43.00	04300	NURSERY	1,342	0	9,034	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	33,980	377,385	82,712	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	16,070	75,708	35,776	0	52.00
53.00	05300	ANESTHESIOLOGY	455	63,831	2,330	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	36,754	399,225	48,561	0	54.00
54.01	03440	BREAST HEALTH CENTER	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	34,820	26,831	12,988	0	55.00
56.00	05600	RADIOISOTOPE	3,356	2,828	7,408	0	56.00
56.10	03630	ULTRASOUND	2,340	46,013	16,319	0	56.10
57.00	05700	CT SCAN	1,573	199	14,547	0	57.00
58.00	05800	MRI	1,676	16,412	9,706	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	8,460	116,536	19,541	0	59.00
60.00	06000	LABORATORY	12,380	77,358	80,943	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	2,420	61,965	38,827	0	65.00
65.01	03952	SLEEP LAB	2,660	11,862	4,272	0	65.01
66.00	06600	PHYSICAL THERAPY	6,930	8,502	28,945	0	66.00
68.00	06800	SPEECH PATHOLOGY	225	909	4,120	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,619	46,145	24,560	0	69.00
69.01	06901	C-PORT	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	1,560	5,662	2,306	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,772	19,590	10,281	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	1,640	17,593	10,860	0	74.00
75.10	03340	GI LAB	7,710	195,699	20,132	0	75.10
76.00	03951	ENTEROSTOMAL THERAPY	0	0	0	0	76.00
76.10	03950	NEUROLOGY	0	0	0	0	76.10
76.20	03290	EMG	0	0	0	0	76.20
76.30	03953	OS SVCS	0	0	0	0	76.30
76.40	03040	AUDIOLOGY	0	0	0	15,336	76.40
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	2,110	5,810	11,261	0	90.00
90.01	09001	PALOS DIAGNOSTIC CENTER	0	7,890	3,168	0	90.01
90.02	09002	CARE STATIONS	0	16,610	29,437	0	90.02
90.03	09003	OUTPATIENT CARE CENTER	0	58,553	35,602	0	90.03
91.00	09100	EMERGENCY	14,810	43,764	103,839	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0179

Period:
From 07/01/2019
To 01/31/2020

Worksheet B-1

Date/Time Prepared:
7/28/2020 8:27 am

Cost Center Description			CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (FTE'S SALARIES))	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
			BLDG & FIXT ((SQUARE FEET))	MVBLE EQUIP (DOLLAR VALUE)				
			1.00	2.00	4.00	5A	5.00	
93.00	04951	OUTPATIENT REHAB	10,910	391	17,837	0	930,286	93.00
93.10	04950	WOUND CARE CENTER	1,670	3,698	8,780	0	602,836	93.10
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	0	17,351	18,931	0	1,432,796	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	15,081	13,349	0	890,041	116.00
117.00	06950	MOBILE MED	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	522,309	3,638,248	1,805,363	-27,283,299	106,105,426	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,060	0	0	0	10,929	190.00
191.10	19101	ADULT DAY CARE	0	0	0	0	0	191.10
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,830	1,866	6,254	0	494,210	192.00
192.01	19201	VACANT SPACE	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	1,890	0	0	0	19,487	193.00
194.00	07950	FUND DEVELOPMENT	2,717	0	0	0	28,014	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)	5,462,582	3,628,293	1,719,990		27,745,138	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	10.310533	0.996753	0.949423		0.260132	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			7,842		1,530,672	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.004329		0.014351	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: 14-0179

Period:
From 07/01/2019
To 01/31/2020

Worksheet B-1

Date/Time Prepared:
7/28/2020 8:27 am

Cost Center Description			MAINTENANCE & REPAIRS ((SQUARE FEET))	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE ((POUNDS OF LAUNDRY))	HOUSEKEEPING (SQUARE FEET)	DIETARY ((MEALS SERVED))	
			6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	0					6.00
7.00	00700	OPERATION OF PLANT	0	430,223				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	9,080	469,601			8.00
9.00	00900	HOUSEKEEPING	0	3,699	5,767	417,444		9.00
10.00	01000	DIETARY	0	11,430	0	11,430	95,916	10.00
11.00	01100	CAFETERIA	0	7,920	0	7,920	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	1,088	0	1,088	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0	0	14.00
15.00	01500	PHARMACY	0	4,417	71	4,417	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	8,450	0	8,450	0	16.00
17.00	01700	SOCIAL SERVICE	0	638	0	638	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	1,730	0	1,730	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	0	119,442	120,248	119,442	84,102	30.00
31.00	03100	INTENSIVE CARE UNIT	0	12,500	12,987	12,500	8,133	31.00
34.10	02060	NICU	0	17,300	2,493	17,300	0	34.10
40.00	04000	SUBPROVIDER - IPF	0	13,790	2,063	13,790	3,681	40.00
43.00	04300	NURSERY	0	1,342	0	1,342	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	33,980	176,414	33,980	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	16,070	33,169	16,070	0	52.00
53.00	05300	ANESTHESIOLOGY	0	455	0	455	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	36,754	21,869	36,754	0	54.00
54.01	03440	BREAST HEALTH CENTER	0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	34,820	1,738	34,820	0	55.00
56.00	05600	RADIOISOTOPE	0	3,356	3,110	3,356	0	56.00
56.10	03630	ULTRASOUND	0	2,340	6,310	2,340	0	56.10
57.00	05700	CT SCAN	0	1,573	7,634	1,573	0	57.00
58.00	05800	MRI	0	1,676	1,608	1,676	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	8,460	1,263	8,460	0	59.00
60.00	06000	LABORATORY	0	12,380	1,462	12,380	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	2,420	4	2,420	0	65.00
65.01	03952	SLEEP LAB	0	2,660	513	2,660	0	65.01
66.00	06600	PHYSICAL THERAPY	0	6,930	6,423	6,930	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	225	0	225	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,619	1,809	1,619	0	69.00
69.01	06901	C-PORT	0	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,560	387	1,560	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	3,772	0	3,772	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	1,640	2,369	1,640	0	74.00
75.10	03340	GI LAB	0	7,710	4,646	7,710	0	75.10
76.00	03951	ENTEROSTOMAL THERAPY	0	0	0	0	0	76.00
76.10	03950	NEUROLOGY	0	0	0	0	0	76.10
76.20	03290	EMG	0	0	0	0	0	76.20
76.30	03953	OS SVCS	0	0	0	0	0	76.30
76.40	03040	AUDIOLOGY	0	0	0	0	0	76.40
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	2,110	425	2,110	0	90.00
90.01	09001	PALOS DIAGNOSTIC CENTER	0	0	0	0	0	90.01
90.02	09002	CARE STATIONS	0	0	1,488	0	0	90.02
90.03	09003	OUTPATIENT CARE CENTER	0	0	4,103	0	0	90.03
91.00	09100	EMERGENCY	0	14,810	47,775	14,810	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
93.00	04951	OUTPATIENT REHAB	0	10,910	0	10,910	0	93.00
93.10	04950	WOUND CARE CENTER	0	1,670	1,453	1,670	0	93.10

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0179

Period:
From 07/01/2019
To 01/31/2020

Worksheet B-1

Date/Time Prepared:
7/28/2020 8:27 am

Cost Center Description		MAINTENANCE & REPAIRS ((SQUARE FEET))	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE ((POUNDS OF LAUNDRY))	HOUSEKEEPING (SQUARE FEET)	DIETARY ((MEALS SERVED))	
		6.00	7.00	8.00	9.00	10.00	
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	0	0	0	116.00
117.00	06950	MOBILE MED	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	422,726	469,601	409,947	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,060	0	1,060	190.00
191.10	19101	ADULT DAY CARE	0	0	0	0	191.10
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	1,830	0	1,830	192.00
192.01	19201	VACANT SPACE	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	1,890	0	1,890	193.00
194.00	07950	FUND DEVELOPMENT	0	2,717	0	2,717	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)	0	6,917,278	621,869	2,463,115	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	16.078355	1.324250	5.900468	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	779,415	116,636	117,733	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	1.811653	0.248373	0.282033	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: 14-0179

Period:
From 07/01/2019
To 01/31/2020

Worksheet B-1

Date/Time Prepared:
7/28/2020 8:27 am

Cost Center Description			CAFETERIA ((MEALS SERVED))	MAINTENANCE OF PERSONNEL ((NUMBER HOUSED))	NURSING ADMINISTRATION ((DIRECT NRSG HRS))	CENTRAL SERVICES & SUPPLY ((COSTED REQUIS))	PHARMACY ((COSTED REQUIS))	
			11.00	12.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	1,274,156					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	54,384	0	908,831			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	0		14.00
15.00	01500	PHARMACY	40,365	0	0	0	9,385,105	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	65,198	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	12,738	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	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	389,989	0	389,989	0	5,100	30.00
31.00	03100	INTENSIVE CARE UNIT	56,094	0	56,094	0	4,216	31.00
34.10	02060	NICU	15,507	0	15,507	0	58	34.10
40.00	04000	SUBPROVIDER - IPF	17,739	0	17,739	0	41	40.00
43.00	04300	NURSERY	9,034	0	9,034	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	82,712	0	82,712	0	7,224	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	35,776	0	35,776	0	192	52.00
53.00	05300	ANESTHESIOLOGY	2,330	0	2,330	0	23,004	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	48,561	0	48,561	0	143,292	54.00
54.01	03440	BREAST HEALTH CENTER	0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	12,988	0	12,988	0	3,489	55.00
56.00	05600	RADIOISOTOPE	7,408	0	7,408	0	194,528	56.00
56.10	03630	ULTRASOUND	16,319	0	0	0	241	56.10
57.00	05700	CT SCAN	14,547	0	0	0	35,989	57.00
58.00	05800	MRI	9,706	0	0	0	23,152	58.00
59.00	05900	CARDIAC CATHETERIZATION	10,541	0	0	0	21,580	59.00
60.00	06000	LABORATORY	80,943	0	0	0	51	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	38,827	0	38,827	0	560	65.00
65.01	03952	SLEEP LAB	4,272	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	28,945	0	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	4,120	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	24,560	0	0	0	4,968	69.00
69.01	06901	C-PORT	0	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	2,306	0	2,306	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	10,281	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	8,859,487	73.00
74.00	07400	RENAL DIALYSIS	10,860	0	0	0	0	74.00
75.10	03340	GI LAB	20,132	0	20,132	0	484	75.10
76.00	03951	ENTEROSTOMAL THERAPY	0	0	0	0	0	76.00
76.10	03950	NEUROLOGY	0	0	0	0	0	76.10
76.20	03290	EMG	0	0	0	0	0	76.20
76.30	03953	OS SVCS	0	0	0	0	0	76.30
76.40	03040	AUDIOLOGY	0	0	0	0	0	76.40
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPS	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	11,261	0	11,261	0	6,200	90.00
90.01	09001	PALOS DIAGNOSTIC CENTER	0	0	0	0	0	90.01
90.02	09002	CARE STATIONS	0	0	0	0	21,985	90.02
90.03	09003	OUTPATIENT CARE CENTER	0	0	0	0	15,500	90.03
91.00	09100	EMERGENCY	103,839	0	103,839	0	3,206	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
93.00	04951	OUTPATIENT REHAB	17,837	0	17,837	0	421	93.00
93.10	04950	WOUND CARE CENTER	8,780	0	8,780	0	4,060	93.10

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0179

Period:
From 07/01/2019
To 01/31/2020

Worksheet B-1

Date/Time Prepared:
7/28/2020 8:27 am

Cost Center Description			CAFETERIA ((MEALS SERVED))	MAINTENANCE OF PERSONNEL ((NUMBER HOUSED))	NURSING ADMINISTRATION ((DIRECT NRSG HRS))	CENTRAL SERVICES & SUPPLY ((COSTED REQUIS))	PHARMACY ((COSTED REQUIS))	
			11.00	12.00	13.00	14.00	15.00	
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	0	0	18,931	0	29	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	0	0	8,780	0	6,048	116.00
117.00	06950	MOBILE MED	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,268,899	0	908,831	0	9,385,105	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.10	19101	ADULT DAY CARE		0	0	0	0	191.10
192.00	19200	PHYSICIANS' PRIVATE OFFICES	5,257	0	0	0	0	192.00
192.01	19201	VACANT SPACE	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	FUND DEVELOPMENT	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)	755,120	0	2,972,155	-461,839	3,488,089	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.592643	0.000000	3.270305	0.000000	0.371662	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	107,162	0	554,539	0	172,477	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.084104	0.000000	0.610167	0.000000	0.018378	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: 14-0179

Period:
From 07/01/2019
To 01/31/2020

Worksheet B-1

Date/Time Prepared:
7/28/2020 8:27 am

Cost Center Description			MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE ((TIME SPENT))	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	636,958,064					16.00
17.00	01700	SOCIAL SERVICE	0	45,804				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			0	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	80,808,401	28,053	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	10,272,517	2,711	0	0	0	31.00
34.10	02060	NICU	3,793,006	870	0	0	0	34.10
40.00	04000	SUBPROVIDER - IPF	2,834,795	1,227	0	0	0	40.00
43.00	04300	NURSERY	2,179,872	10,653	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	28,866,256	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,140,072	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	10,668,805	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	29,368,454	0	0	0	0	54.00
54.01	03440	BREAST HEALTH CENTER	0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	9,900,242	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	7,749,467	0	0	0	0	56.00
56.10	03630	ULTRASOUND	12,210,081	0	0	0	0	56.10
57.00	05700	CT SCAN	59,695,621	0	0	0	0	57.00
58.00	05800	MRI	7,788,184	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	13,620,226	0	0	0	0	59.00
60.00	06000	LABORATORY	94,714,093	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	21,690,176	0	0	0	0	65.00
65.01	03952	SLEEP LAB	1,191,971	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	6,737,210	0	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	1,536,529	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	12,398,157	0	0	0	0	69.00
69.01	06901	C-PORT	0	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	1,183,811	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	14,228,360	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,986,161	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	82,821,669	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	3,616,579	0	0	0	0	74.00
75.10	03340	GI LAB	12,738,806	0	0	0	0	75.10
76.00	03951	ENTEROSTOMAL THERAPY	0	0	0	0	0	76.00
76.10	03950	NEUROLOGY	0	0	0	0	0	76.10
76.20	03290	EMG	0	0	0	0	0	76.20
76.30	03953	OS SVCS	17,363	0	0	0	0	76.30
76.40	03040	AUDIOLOGY	0	0	0	0	0	76.40
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	997,477	0	0	0	0	90.00
90.01	09001	PALOS DIAGNOSTIC CENTER	391,164	0	0	0	0	90.01
90.02	09002	CARE STATIONS	3,636,544	0	0	0	0	90.02
90.03	09003	OUTPATIENT CARE CENTER	12,209,325	0	0	0	0	90.03
91.00	09100	EMERGENCY	62,623,400	2,290	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0179

Period:
From 07/01/2019
To 01/31/2020

Worksheet B-1

Date/Time Prepared:
7/28/2020 8:27 am

Cost Center Description			MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE ((TIME SPENT))	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	
93.00	04951	OUTPATIENT REHAB	2,823,976	0	0	0	0	93.00
93.10	04950	WOUND CARE CENTER	2,220,772	0	0	0	0	93.10
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	1,549,106	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	749,416	0		0		116.00
117.00	06950	MOBILE MED	0	0	0	0	0	117.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	636,958,064	45,804	0	0	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.10	19101	ADULT DAY CARE	0	0	0	0	0	191.10
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	VACANT SPACE	0	0	0	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
194.00	07950	FUND DEVELOPMENT	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)	4,816,025	904,344	0	0	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.007561	19.743778	0.000000	0.000000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	165,892	19,093	0	0	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000260	0.416841	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: 14-0179

Period:
From 07/01/2019
To 01/31/2020

Worksheet B-1

Date/Time Prepared:
7/28/2020 8:27 am

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)		23.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	1,000	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
34.10	02060	NICU	0	34.10
40.00	04000	SUBPROVIDER - IPF	0	40.00
43.00	04300	NURSERY	0	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	52.00
53.00	05300	ANESTHESIOLOGY	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54.00
54.01	03440	BREAST HEALTH CENTER	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	55.00
56.00	05600	RADIOISOTOPE	0	56.00
56.10	03630	ULTRASOUND	0	56.10
57.00	05700	CT SCAN	0	57.00
58.00	05800	MRI	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	59.00
60.00	06000	LABORATORY	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	65.00
65.01	03952	SLEEP LAB	0	65.01
66.00	06600	PHYSICAL THERAPY	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	69.00
69.01	06901	C-PORT	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73.00
74.00	07400	RENAL DIALYSIS	0	74.00
75.10	03340	GI LAB	0	75.10
76.00	03951	ENTEROSTOMAL THERAPY	0	76.00
76.10	03950	NEUROLOGY	0	76.10
76.20	03290	EMG	0	76.20
76.30	03953	OS SVCS	0	76.30
76.40	03040	AUDIOLOGY	0	76.40
76.97	07697	CARDIAC REHABILITATION	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	76.98
76.99	07699	LITHOTRIPSY	0	76.99
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	90.00
90.01	09001	PALOS DIAGNOSTIC CENTER	0	90.01
90.02	09002	CARE STATIONS	0	90.02
90.03	09003	OUTPATIENT CARE CENTER	0	90.03
91.00	09100	EMERGENCY	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		92.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0179

Period:
From 07/01/2019
To 01/31/2020Worksheet B-1
Date/Time Prepared:
7/28/2020 8:27 am

Cost Center Description			INTERNS & RESIDENTS	PARAMED ED PRGM ((ASSIGNED TIME))	
			SERVICES-OTHER PRGM COSTS APPRV ((ASSIGNED TIME))		
			22.00	23.00	
93.00	04951	OUTPATIENT REHAB	0	0	93.00
93.10	04950	WOUND CARE CENTER	0	0	93.10
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	99.40
101.00	10100	HOME HEALTH AGENCY	0	0	101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
116.00	11600	HOSPICE		0	116.00
117.00	06950	MOBILE MED	0	0	117.00
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
191.10	19101	ADULT DAY CARE	0	0	191.10
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
192.01	19201	VACANT SPACE	0	0	192.01
193.00	19300	NONPAID WORKERS	0	0	193.00
194.00	07950	FUND DEVELOPMENT	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)	138,923	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	138.923000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	22,608	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	22.608000	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)		0	206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)		0.000000	207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0179

Period:
From 07/01/2019
To 01/31/2020Worksheet C
Part I
Date/Time Prepared:
7/28/2020 8:27 am

				Title XVIII		Hospital		PPS	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Costs		Total Costs	
						RCE Disallowance			
			1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	29,845,111		29,845,111	0	29,845,111	30.00	
31.00	03100	INTENSIVE CARE UNIT	4,948,937		4,948,937	13,233	4,962,170	31.00	
34.10	02060	NICU	1,925,509		1,925,509	0	1,925,509	34.10	
40.00	04000	SUBPROVIDER - IPF	1,795,783		1,795,783	20,191	1,815,974	40.00	
43.00	04300	NURSERY	901,133		901,133	0	901,133	43.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	8,995,321		8,995,321	0	8,995,321	50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,166,823		3,166,823	0	3,166,823	52.00	
53.00	05300	ANESTHESIOLOGY	559,748		559,748	0	559,748	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,737,995		5,737,995	0	5,737,995	54.00	
54.01	03440	BREAST HEALTH CENTER	0		0	0	0	54.01	
55.00	05500	RADIOLOGY-THERAPEUTIC	3,399,986		3,399,986	0	3,399,986	55.00	
56.00	05600	RADIOISOTOPE	1,416,921		1,416,921	0	1,416,921	56.00	
56.10	03630	ULTRASOUND	1,405,990		1,405,990	0	1,405,990	56.10	
57.00	05700	CT SCAN	1,701,038		1,701,038	0	1,701,038	57.00	
58.00	05800	MRI	874,740		874,740	0	874,740	58.00	
59.00	05900	CARDIAC CATHETERIZATION	1,719,948		1,719,948	129,248	1,849,196	59.00	
60.00	06000	LABORATORY	9,315,214		9,315,214	0	9,315,214	60.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30	
65.00	06500	RESPIRATORY THERAPY	2,724,325	0	2,724,325	13,506	2,737,831	65.00	
65.01	03952	SLEEP LAB	338,233	0	338,233	0	338,233	65.01	
66.00	06600	PHYSICAL THERAPY	2,114,065	0	2,114,065	0	2,114,065	66.00	
68.00	06800	SPEECH PATHOLOGY	326,099	0	326,099	0	326,099	68.00	
69.00	06900	ELECTROCARDIOLOGY	1,826,713		1,826,713	17,836	1,844,549	69.00	
69.01	06901	C-PORT	0		0	0	0	69.01	
70.00	07000	ELECTROENCEPHALOGRAPHY	239,553		239,553	0	239,553	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,214,028		6,214,028	0	6,214,028	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,942,157		3,942,157	0	3,942,157	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	15,501,110		15,501,110	0	15,501,110	73.00	
74.00	07400	RENAL DIALYSIS	1,055,620		1,055,620	4,953	1,060,573	74.00	
75.10	03340	GI LAB	2,356,537		2,356,537	0	2,356,537	75.10	
76.00	03951	ENTEROSTOMAL THERAPY	0		0	0	0	76.00	
76.10	03950	NEUROLOGY	0		0	0	0	76.10	
76.20	03290	EMG	0		0	0	0	76.20	
76.30	03953	OS SVCS	19,456		19,456	0	19,456	76.30	
76.40	03040	AUDIOLOGY	0		0	0	0	76.40	
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	783,124		783,124	0	783,124	90.00	
90.01	09001	PALOS DIAGNOSTIC CENTER	182,578		182,578	0	182,578	90.01	
90.02	09002	CARE STATIONS	1,944,043		1,944,043	11,656	1,955,699	90.02	
90.03	09003	OUTPATIENT CARE CENTER	2,530,865		2,530,865	0	2,530,865	90.03	
91.00	09100	EMERGENCY	8,200,965		8,200,965	0	8,200,965	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	4,412,850		4,412,850	0	4,412,850	92.00	
93.00	04951	OUTPATIENT REHAB	1,502,483		1,502,483	5,631	1,508,114	93.00	
93.10	04950	WOUND CARE CENTER	850,498		850,498	7,538	858,036	93.10	
OTHER REIMBURSABLE COST CENTERS									
99.10	09910	CORF	0		0	0	0	99.10	
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0		0	0	0	99.20	
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0		0	0	0	99.30	
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0		0	0	0	99.40	
101.00	10100	HOME HEALTH AGENCY	1,879,146		1,879,146	0	1,879,146	101.00	
SPECIAL PURPOSE COST CENTERS									
113.00	11300	INTEREST EXPENSE	0		0	0	0	113.00	
116.00	11600	HOSPICE	1,158,196		1,158,196	0	1,158,196	116.00	
117.00	06950	MOBILE MED	0		0	0	0	117.00	
200.00		Subtotal (see instructions)	137,812,841	0	137,812,841	223,792	138,036,633	200.00	
201.00		Less Observation Beds	4,412,850		4,412,850	0	4,412,850	201.00	
202.00		Total (see instructions)	133,399,991	0	133,399,991	223,792	133,623,783	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0179

Period:
From 07/01/2019
To 01/31/2020Worksheet C
Part I
Date/Time Prepared:
7/28/2020 8:27 am

			Title XVIII		Hospital	PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00	9.00	10.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	71,107,740		71,107,740		30.00
31.00	03100	INTENSIVE CARE UNIT	10,272,517		10,272,517		31.00
34.10	02060	NICU	3,793,006		3,793,006		34.10
40.00	04000	SUBPROVIDER - IPF	2,834,795		2,834,795		40.00
43.00	04300	NURSERY	2,179,872		2,179,872		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	11,288,724	17,577,532	28,866,256	0.311621	0.000000
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,797,633	342,439	6,140,072	0.515763	0.000000
53.00	05300	ANESTHESIOLOGY	4,988,093	5,680,712	10,668,805	0.052466	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	9,534,595	19,833,859	29,368,454	0.195380	0.000000
54.01	03440	BREAST HEALTH CENTER	0	0	0	0.000000	0.000000
55.00	05500	RADIOLOGY-THERAPEUTIC	397,891	9,502,351	9,900,242	0.343425	0.000000
56.00	05600	RADIOISOTOPE	2,163,673	5,585,794	7,749,467	0.182841	0.000000
56.10	03630	ULTRASOUND	3,590,844	8,619,237	12,210,081	0.115150	0.000000
57.00	05700	CT SCAN	20,082,601	39,613,020	59,695,621	0.028495	0.000000
58.00	05800	MRI	3,378,861	4,409,323	7,788,184	0.112316	0.000000
59.00	05900	CARDIAC CATHETERIZATION	9,528,233	4,091,993	13,620,226	0.126279	0.000000
60.00	06000	LABORATORY	38,572,060	56,142,033	94,714,093	0.098351	0.000000
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000
65.00	06500	RESPIRATORY THERAPY	18,716,535	2,973,641	21,690,176	0.125602	0.000000
65.01	03952	SLEEP LAB	0	1,191,971	1,191,971	0.283759	0.000000
66.00	06600	PHYSICAL THERAPY	2,396,529	4,340,681	6,737,210	0.313789	0.000000
68.00	06800	SPEECH PATHOLOGY	1,096,897	439,632	1,536,529	0.212231	0.000000
69.00	06900	ELECTROCARDIOLOGY	6,545,163	5,852,994	12,398,157	0.147337	0.000000
69.01	06901	C-PORT	0	0	0	0.000000	0.000000
70.00	07000	ELECTROENCEPHALOGRAPHY	359,709	824,102	1,183,811	0.202357	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	9,308,525	4,919,835	14,228,360	0.436735	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,604,689	3,381,472	10,986,161	0.358829	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	33,467,109	49,354,560	82,821,669	0.187162	0.000000
74.00	07400	RENAL DIALYSIS	3,034,815	581,764	3,616,579	0.291884	0.000000
75.10	03340	GI LAB	2,896,876	9,841,930	12,738,806	0.184989	0.000000
76.00	03951	ENTEROSTOMAL THERAPY	0	0	0	0.000000	0.000000
76.10	03950	NEUROLOGY	0	0	0	0.000000	0.000000
76.20	03290	EMG	0	0	0	0.000000	0.000000
76.30	03953	OS SVCS	13,570	3,793	17,363	1.120544	0.000000
76.40	03040	AUDIOLOGY	0	0	0	0.000000	0.000000
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	116,619	880,858	997,477	0.785105	0.000000
90.01	09001	PALOS DIAGNOSTIC CENTER	156	391,008	391,164	0.466756	0.000000
90.02	09002	CARE STATIONS	11,421	3,625,123	3,636,544	0.534585	0.000000
90.03	09003	OUTPATIENT CARE CENTER	21,440	12,187,885	12,209,325	0.207290	0.000000
91.00	09100	EMERGENCY	20,711,807	41,911,593	62,623,400	0.130957	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,537,564	7,163,097	9,700,661	0.454902	0.000000
93.00	04951	OUTPATIENT REHAB	5,501	2,818,475	2,823,976	0.532045	0.000000
93.10	04950	WOUND CARE CENTER	3,713	2,217,059	2,220,772	0.382974	0.000000
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0		99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0		99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0		99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0		99.40
101.00	10100	HOME HEALTH AGENCY	0	1,549,106	1,549,106		101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	749,416	749,416		116.00
117.00	06950	MOBILE MED	0	0	0		117.00
200.00		Subtotal (see instructions)	308,359,776	328,598,288	636,958,064		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	308,359,776	328,598,288	636,958,064		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0179

Period:
From 07/01/2019
To 01/31/2020Worksheet C
Part I
Date/Time Prepared:
7/28/2020 8:27 am

Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital	PPS
		11.00			
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
34.10	02060	NICU			34.10
40.00	04000	SUBPROVIDER - IPF			40.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.311621		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.515763		52.00
53.00	05300	ANESTHESIOLOGY	0.052466		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.195380		54.00
54.01	03440	BREAST HEALTH CENTER	0.000000		54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.343425		55.00
56.00	05600	RADIOISOTOPE	0.182841		56.00
56.10	03630	ULTRASOUND	0.115150		56.10
57.00	05700	CT SCAN	0.028495		57.00
58.00	05800	MRI	0.112316		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.135768		59.00
60.00	06000	LABORATORY	0.098351		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000		62.30
65.00	06500	RESPIRATORY THERAPY	0.126224		65.00
65.01	03952	SLEEP LAB	0.283759		65.01
66.00	06600	PHYSICAL THERAPY	0.313789		66.00
68.00	06800	SPEECH PATHOLOGY	0.212231		68.00
69.00	06900	ELECTROCARDIOLOGY	0.148776		69.00
69.01	06901	C-PORT	0.000000		69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.202357		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.436735		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.358829		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.187162		73.00
74.00	07400	RENAL DIALYSIS	0.293253		74.00
75.10	03340	GI LAB	0.184989		75.10
76.00	03951	ENTEROSTOMAL THERAPY	0.000000		76.00
76.10	03950	NEUROLOGY	0.000000		76.10
76.20	03290	EMG	0.000000		76.20
76.30	03953	OS SVCS	1.120544		76.30
76.40	03040	AUDIOLOGY	0.000000		76.40
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	0.785105		90.00
90.01	09001	PALOS DIAGNOSTIC CENTER	0.466756		90.01
90.02	09002	CARE STATIONS	0.537791		90.02
90.03	09003	OUTPATIENT CARE CENTER	0.207290		90.03
91.00	09100	EMERGENCY	0.130957		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.454902		92.00
93.00	04951	OUTPATIENT REHAB	0.534039		93.00
93.10	04950	WOUND CARE CENTER	0.386368		93.10
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF			99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY			99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY			99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY			99.40
101.00	10100	HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE			113.00
116.00	11600	HOSPICE			116.00
117.00	06950	MOBILE MED			117.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0179

Period:
From 07/01/2019
To 01/31/2020Worksheet C
Part I
Date/Time Prepared:
7/28/2020 8:27 am

			Title XIX		Hospital		Cost	
Cost Center Description			Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	
					Total Costs	RCE Disallowance		
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	29,984,034		29,984,034	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	4,948,937		4,948,937	0	0	31.00
34.10	02060	NICU	1,925,509		1,925,509	0	0	34.10
40.00	04000	SUBPROVIDER - IPF	1,795,783		1,795,783	0	0	40.00
43.00	04300	NURSERY	901,133		901,133	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	8,995,321		8,995,321	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,166,823		3,166,823	0	0	52.00
53.00	05300	ANESTHESIOLOGY	559,748		559,748	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,737,995		5,737,995	0	0	54.00
54.01	03440	BREAST HEALTH CENTER	0		0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	3,399,986		3,399,986	0	0	55.00
56.00	05600	RADIOISOTOPE	1,416,921		1,416,921	0	0	56.00
56.10	03630	ULTRASOUND	1,405,990		1,405,990	0	0	56.10
57.00	05700	CT SCAN	1,701,038		1,701,038	0	0	57.00
58.00	05800	MRI	874,740		874,740	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,719,948		1,719,948	0	0	59.00
60.00	06000	LABORATORY	9,315,214		9,315,214	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	2,724,325	0	2,724,325	0	0	65.00
65.01	03952	SLEEP LAB	338,233	0	338,233	0	0	65.01
66.00	06600	PHYSICAL THERAPY	2,114,065	0	2,114,065	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	326,099	0	326,099	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,826,713		1,826,713	0	0	69.00
69.01	06901	C-PORT	0		0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	239,553		239,553	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,214,028		6,214,028	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,942,157		3,942,157	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,501,110		15,501,110	0	0	73.00
74.00	07400	RENAL DIALYSIS	1,055,620		1,055,620	0	0	74.00
75.10	03340	GI LAB	2,356,537		2,356,537	0	0	75.10
76.00	03951	ENTEROSTOMAL THERAPY	0		0	0	0	76.00
76.10	03950	NEUROLOGY	0		0	0	0	76.10
76.20	03290	EMG	0		0	0	0	76.20
76.30	03953	OS SVCS	19,456		19,456	0	0	76.30
76.40	03040	AUDIOLOGY	0		0	0	0	76.40
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	783,124		783,124	0	0	90.00
90.01	09001	PALOS DIAGNOSTIC CENTER	182,578		182,578	0	0	90.01
90.02	09002	CARE STATIONS	1,944,043		1,944,043	0	0	90.02
90.03	09003	OUTPATIENT CARE CENTER	2,530,865		2,530,865	0	0	90.03
91.00	09100	EMERGENCY	8,200,965		8,200,965	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	4,433,403		4,433,403	0	0	92.00
93.00	04951	OUTPATIENT REHAB	1,502,483		1,502,483	0	0	93.00
93.10	04950	WOUND CARE CENTER	850,498		850,498	0	0	93.10
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0		0		0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0		0		0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0		0		0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0		0		0	99.40
101.00	10100	HOME HEALTH AGENCY	1,879,146		1,879,146		0	101.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
116.00	11600	HOSPICE	1,158,196		1,158,196		0	116.00
117.00	06950	MOBILE MED	0		0		0	117.00
200.00		Subtotal (see instructions)	137,972,317	0	137,972,317	0	0	200.00
201.00		Less Observation Beds	4,433,403		4,433,403		0	201.00
202.00		Total (see instructions)	133,538,914	0	133,538,914	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0179

Period:
From 07/01/2019
To 01/31/2020Worksheet C
Part I
Date/Time Prepared:
7/28/2020 8:27 am

			Title XIX		Hospital	Cost	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio
			Inpatient	Outpatient	Total (col. 6 + col. 7)		
			6.00	7.00	8.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0		0		30.00
31.00	03100	INTENSIVE CARE UNIT	0		0		31.00
34.10	02060	NICU	0		0		34.10
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	0	0.000000	0.000000
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0.000000	0.000000
54.01	03440	BREAST HEALTH CENTER	0	0	0	0.000000	0.000000
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0.000000	0.000000
56.00	05600	RADIOISOTOPE	0	0	0	0.000000	0.000000
56.10	03630	ULTRASOUND	0	0	0	0.000000	0.000000
57.00	05700	CT SCAN	0	0	0	0.000000	0.000000
58.00	05800	MRI	0	0	0	0.000000	0.000000
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000
60.00	06000	LABORATORY	0	0	0	0.000000	0.000000
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000
65.00	06500	RESPIRATORY THERAPY	0	0	0	0.000000	0.000000
65.01	03952	SLEEP LAB	0	0	0	0.000000	0.000000
66.00	06600	PHYSICAL THERAPY	0	0	0	0.000000	0.000000
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	0.000000
69.01	06901	C-PORT	0	0	0	0.000000	0.000000
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0.000000	0.000000
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0.000000	0.000000
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	0.000000
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0.000000	0.000000
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000
75.10	03340	GI LAB	0	0	0	0.000000	0.000000
76.00	03951	ENTEROSTOMAL THERAPY	0	0	0	0.000000	0.000000
76.10	03950	NEUROLOGY	0	0	0	0.000000	0.000000
76.20	03290	EMG	0	0	0	0.000000	0.000000
76.30	03953	OS SVCS	0	0	0	0.000000	0.000000
76.40	03040	AUDIOLOGY	0	0	0	0.000000	0.000000
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0.000000	0.000000
90.01	09001	PALOS DIAGNOSTIC CENTER	0	0	0	0.000000	0.000000
90.02	09002	CARE STATIONS	0	0	0	0.000000	0.000000
90.03	09003	OUTPATIENT CARE CENTER	0	0	0	0.000000	0.000000
91.00	09100	EMERGENCY	0	0	0	0.000000	0.000000
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0.000000	0.000000
93.00	04951	OUTPATIENT REHAB	0	0	0	0.000000	0.000000
93.10	04950	WOUND CARE CENTER	0	0	0	0.000000	0.000000
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0		99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0		99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0		99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0		99.40
101.00	10100	HOME HEALTH AGENCY	0	0	0		101.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
116.00	11600	HOSPICE	0	0	0		116.00
117.00	06950	MOBILE MED	0	0	0		117.00
200.00		Subtotal (see instructions)	0	0	0		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	0	0	0		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0179

Period:
From 07/01/2019
To 01/31/2020Worksheet C
Part I
Date/Time Prepared:
7/28/2020 8:27 am

Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital	Cost
			11.00			
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				30.00
31.00	03100	INTENSIVE CARE UNIT				31.00
34.10	02060	NICU				34.10
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
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
54.01	03440	BREAST HEALTH CENTER	0.000000			54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000			55.00
56.00	05600	RADIOISOTOPE	0.000000			56.00
56.10	03630	ULTRASOUND	0.000000			56.10
57.00	05700	CT SCAN	0.000000			57.00
58.00	05800	MRI	0.000000			58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000			59.00
60.00	06000	LABORATORY	0.000000			60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000			62.30
65.00	06500	RESPIRATORY THERAPY	0.000000			65.00
65.01	03952	SLEEP LAB	0.000000			65.01
66.00	06600	PHYSICAL THERAPY	0.000000			66.00
68.00	06800	SPEECH PATHOLOGY	0.000000			68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000			69.00
69.01	06901	C-PORT	0.000000			69.01
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
74.00	07400	RENAL DIALYSIS	0.000000			74.00
75.10	03340	GI LAB	0.000000			75.10
76.00	03951	ENTEROSTOMAL THERAPY	0.000000			76.00
76.10	03950	NEUROLOGY	0.000000			76.10
76.20	03290	EMG	0.000000			76.20
76.30	03953	OS SVCS	0.000000			76.30
76.40	03040	AUDIOLOGY	0.000000			76.40
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	PALOS DIAGNOSTIC CENTER	0.000000			90.01
90.02	09002	CARE STATIONS	0.000000			90.02
90.03	09003	OUTPATIENT CARE CENTER	0.000000			90.03
91.00	09100	EMERGENCY	0.000000			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000			92.00
93.00	04951	OUTPATIENT REHAB	0.000000			93.00
93.10	04950	WOUND CARE CENTER	0.000000			93.10
OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF				99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY				99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY				99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY				99.40
101.00	10100	HOME HEALTH AGENCY				101.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
116.00	11600	HOSPICE				116.00
117.00	06950	MOBILE MED				117.00
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: 14-0179

Period:
From 07/01/2019
To 01/31/2020Worksheet D
Part I
Date/Time Prepared:
7/28/2020 8:27 am

			Title XVIII		Hospital	PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	2,359,514	0	2,359,514	32,707	72.14	30.00
31.00	INTENSIVE CARE UNIT	302,829		302,829	2,709	111.79	31.00
34.10	NICU	261,124		261,124	867	301.18	34.10
40.00	SUBPROVIDER - IPF	213,998	0	213,998	1,227	174.41	40.00
43.00	NURSERY	34,911		34,911	1,039	33.60	43.00
200.00	Total (lines 30 through 199)	3,172,376		3,172,376	38,549		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	10,216	736,982				
31.00	INTENSIVE CARE UNIT	886	99,046				
34.10	NICU	0	0				
40.00	SUBPROVIDER - IPF	322	56,160				
43.00	NURSERY	0	0				
200.00	Total (lines 30 through 199)	11,424	892,188				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0179

Period:
From 07/01/2019
To 01/31/2020Worksheet D
Part II
Date/Time Prepared:
7/28/2020 8:27 am

			Title XVIII		Hospital	PPS		
	Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	998,910	28,866,256	0.034605	4,800,661	166,127	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	340,441	6,140,072	0.055446	5,109	283	52.00
53.00	05300	ANESTHESIOLOGY	79,450	10,668,805	0.007447	1,496,921	11,148	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	955,797	29,368,454	0.032545	4,041,495	131,530	54.00
54.01	03440	BREAST HEALTH CENTER	0	0	0.000000	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	500,182	9,900,242	0.050522	134,280	6,784	55.00
56.00	05600	RADIOISOTOPE	69,895	7,749,467	0.009019	1,021,521	9,213	56.00
56.10	03630	ULTRASOUND	95,356	12,210,081	0.007810	1,527,304	11,928	56.10
57.00	05700	CT SCAN	52,547	59,695,621	0.000880	8,107,474	7,135	57.00
58.00	05800	MRI	49,981	7,788,184	0.006418	1,209,471	7,762	58.00
59.00	05900	CARDIAC CATHETERIZATION	245,666	13,620,226	0.018037	2,636,756	47,559	59.00
60.00	06000	LABORATORY	358,067	94,714,093	0.003781	14,294,834	54,049	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	179,200	21,690,176	0.008262	6,700,951	55,363	65.00
65.01	03952	SLEEP LAB	48,747	1,191,971	0.040896	0	0	65.01
66.00	06600	PHYSICAL THERAPY	122,998	6,737,210	0.018257	1,008,928	18,420	66.00
68.00	06800	SPEECH PATHOLOGY	22,706	1,536,529	0.014777	488,429	7,218	68.00
69.00	06900	ELECTROCARDIOLOGY	92,280	12,398,157	0.007443	2,702,673	20,116	69.00
69.01	06901	C-PORT	0	0	0.000000	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	29,137	1,183,811	0.024613	131,139	3,228	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	195,276	14,228,360	0.013724	3,556,003	48,803	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	46,805	10,986,161	0.004260	2,840,087	12,099	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	316,254	82,821,669	0.003818	12,888,963	49,210	73.00
74.00	07400	RENAL DIALYSIS	52,422	3,616,579	0.014495	1,588,802	23,030	74.00
75.10	03340	GI LAB	332,416	12,738,806	0.026095	1,121,304	29,260	75.10
76.00	03951	ENTEROSTOMAL THERAPY	0	0	0.000000	0	0	76.00
76.10	03950	NEUROLOGY	0	0	0.000000	0	0	76.10
76.20	03290	EMG	0	0	0.000000	0	0	76.20
76.30	03953	OS SVCS	225	17,363	0.012959	4,533	59	76.30
76.40	03040	AUDIOLOGY	0	0	0.000000	0	0	76.40
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	48,303	997,477	0.048425	18,784	910	90.00
90.01	09001	PALOS DIAGNOSTIC CENTER	38,838	391,164	0.099288	0	0	90.01
90.02	09002	CARE STATIONS	226,094	3,636,544	0.062173	8,211	511	90.02
90.03	09003	OUTPATIENT CARE CENTER	257,901	12,209,325	0.021123	4,837	102	90.03
91.00	09100	EMERGENCY	408,053	62,623,400	0.006516	7,916,572	51,584	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	348,876	9,700,661	0.035964	785,868	28,263	92.00
93.00	04951	OUTPATIENT REHAB	162,594	2,823,976	0.057576	2,308	133	93.00
93.10	04950	WOUND CARE CENTER	40,474	2,220,772	0.018225	3,250	59	93.10
200.00		Total (lines 50 through 199)	6,715,891	544,471,612		81,047,468	801,886	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0179		Period: From 07/01/2019 To 01/31/2020		Worksheet D Part III Date/Time Prepared: 7/28/2020 8:27 am		
					Title XVIII		Hospital		PPS		
Cost Center Description			Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost				
			1A	1.00	2A	2.00	3.00				
INPATIENT ROUTINE SERVICE COST CENTERS											
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	0	30.00		
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	0	31.00		
34.10	02060	NICU	0	0	0	0	0	0	34.10		
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	32,707	0.00	10,216		30.00		
31.00	03100	INTENSIVE CARE UNIT		0	2,709	0.00	886		31.00		
34.10	02060	NICU		0	867	0.00	0		34.10		
40.00	04000	SUBPROVIDER - IPF	0	0	1,227	0.00	322		40.00		
43.00	04300	NURSERY		0	1,039	0.00	0		43.00		
200.00	Total (lines 30 through 199)			0	38,549		11,424		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
34.10	02060	NICU	0								34.10
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: 14-0179		Period: From 07/01/2019 To 01/31/2020		Worksheet D Part IV Date/Time Prepared: 7/28/2020 8:27 am	
			Title XVIII		Hospital		PPS	
Cost Center Description			Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	03440	BREAST HEALTH CENTER	0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
56.10	03630	ULTRASOUND	0	0	0	0	0	56.10
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
65.01	03952	SLEEP LAB	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
69.01	06901	C-PORT	0	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
75.10	03340	GI LAB	0	0	0	0	0	75.10
76.00	03951	ENTEROSTOMAL THERAPY	0	0	0	0	0	76.00
76.10	03950	NEUROLOGY	0	0	0	0	0	76.10
76.20	03290	EMG	0	0	0	0	0	76.20
76.30	03953	OS SVCS	0	0	0	0	0	76.30
76.40	03040	AUDIOLOGY	0	0	0	0	0	76.40
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	PALOS DIAGNOSTIC CENTER	0	0	0	0	0	90.01
90.02	09002	CARE STATIONS	0	0	0	0	0	90.02
90.03	09003	OUTPATIENT CARE CENTER	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
93.00	04951	OUTPATIENT REHAB	0	0	0	0	0	93.00
93.10	04950	WOUND CARE CENTER	0	0	0	0	0	93.10
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: 14-0179		Period: From 07/01/2019 To 01/31/2020		Worksheet D Part IV Date/Time Prepared: 7/28/2020 8:27 am	
				Title XVIII		Hospital		PPS	
Cost Center Description				All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
				4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0	28,866,256	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	6,140,072	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	10,668,805	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	29,368,454	0.000000	54.00
54.01	03440	BREAST HEALTH CENTER	0	0	0	0	0	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	9,900,242	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	7,749,467	0.000000	56.00
56.10	03630	ULTRASOUND	0	0	0	0	12,210,081	0.000000	56.10
57.00	05700	CT SCAN	0	0	0	0	59,695,621	0.000000	57.00
58.00	05800	MRI	0	0	0	0	7,788,184	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	13,620,226	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	0	94,714,093	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	21,690,176	0.000000	65.00
65.01	03952	SLEEP LAB	0	0	0	0	1,191,971	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	6,737,210	0.000000	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	1,536,529	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	12,398,157	0.000000	69.00
69.01	06901	C-PORT	0	0	0	0	0	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	1,183,811	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	14,228,360	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	10,986,161	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	82,821,669	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	3,616,579	0.000000	74.00
75.10	03340	GI LAB	0	0	0	0	12,738,806	0.000000	75.10
76.00	03951	ENTEROSTOMAL THERAPY	0	0	0	0	0	0.000000	76.00
76.10	03950	NEUROLOGY	0	0	0	0	0	0.000000	76.10
76.20	03290	EMG	0	0	0	0	0	0.000000	76.20
76.30	03953	OS SVCS	0	0	0	0	17,363	0.000000	76.30
76.40	03040	AUDIOLOGY	0	0	0	0	0	0.000000	76.40
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0	0	0	997,477	0.000000	90.00
90.01	09001	PALOS DIAGNOSTIC CENTER	0	0	0	0	391,164	0.000000	90.01
90.02	09002	CARE STATIONS	0	0	0	0	3,636,544	0.000000	90.02
90.03	09003	OUTPATIENT CARE CENTER	0	0	0	0	12,209,325	0.000000	90.03
91.00	09100	EMERGENCY	0	0	0	0	62,623,400	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	9,700,661	0.000000	92.00
93.00	04951	OUTPATIENT REHAB	0	0	0	0	2,823,976	0.000000	93.00
93.10	04950	WOUND CARE CENTER	0	0	0	0	2,220,772	0.000000	93.10
200.00		Total (lines 50 through 199)	0	0	0	0	544,471,612		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0179

Period:
From 07/01/2019
To 01/31/2020Worksheet D
Part IV
Date/Time Prepared:
7/28/2020 8:27 am

			Title XVIII		Hospital	PPS			
Cost Center Description			Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
			9.00	10.00	11.00	12.00	13.00		
	ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.000000	4,800,661	0	4,844,094	0	50.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	5,109	0	13,087	0	52.00	
53.00	05300	ANESTHESIOLOGY	0.000000	1,496,921	0	1,474,463	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	4,041,495	0	4,719,452	0	54.00	
54.01	03440	BREAST HEALTH CENTER	0.000000	0	0	0	0	54.01	
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	134,280	0	3,095,626	0	55.00	
56.00	05600	RADIOISOTOPE	0.000000	1,021,521	0	2,025,546	0	56.00	
56.10	03630	ULTRASOUND	0.000000	1,527,304	0	1,373,418	0	56.10	
57.00	05700	CT SCAN	0.000000	8,107,474	0	8,706,762	0	57.00	
58.00	05800	MRI	0.000000	1,209,471	0	1,029,059	0	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0.000000	2,636,756	0	1,565,745	0	59.00	
60.00	06000	LABORATORY	0.000000	14,294,834	0	5,542,881	0	60.00	
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30	
65.00	06500	RESPIRATORY THERAPY	0.000000	6,700,951	0	525,489	0	65.00	
65.01	03952	SLEEP LAB	0.000000	0	0	352,674	0	65.01	
66.00	06600	PHYSICAL THERAPY	0.000000	1,008,928	0	9,839	0	66.00	
68.00	06800	SPEECH PATHOLOGY	0.000000	488,429	0	12,218	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	0.000000	2,702,673	0	1,561,308	0	69.00	
69.01	06901	C-PORT	0.000000	0	0	0	0	69.01	
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	131,139	0	98,536	0	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	3,556,003	0	1,563,420	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	2,840,087	0	813,119	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	12,888,963	0	18,503,722	0	73.00	
74.00	07400	RENAL DIALYSIS	0.000000	1,588,802	0	157,135	0	74.00	
75.10	03340	GI LAB	0.000000	1,121,304	0	2,524,464	0	75.10	
76.00	03951	ENTEROSTOMAL THERAPY	0.000000	0	0	0	0	76.00	
76.10	03950	NEUROLOGY	0.000000	0	0	0	0	76.10	
76.20	03290	EMG	0.000000	0	0	0	0	76.20	
76.30	03953	OS SVCS	0.000000	4,533	0	199	0	76.30	
76.40	03040	AUDIOLOGY	0.000000	0	0	0	0	76.40	
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	18,784	0	220,677	0	90.00	
90.01	09001	PALOS DIAGNOSTIC CENTER	0.000000	0	0	130,331	0	90.01	
90.02	09002	CARE STATIONS	0.000000	8,211	0	543,918	0	90.02	
90.03	09003	OUTPATIENT CARE CENTER	0.000000	4,837	0	3,214,208	0	90.03	
91.00	09100	EMERGENCY	0.000000	7,916,572	0	5,953,780	0	91.00	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	785,868	0	1,547,195	0	92.00	
93.00	04951	OUTPATIENT REHAB	0.000000	2,308	0	117,880	0	93.00	
93.10	04950	WOUND CARE CENTER	0.000000	3,250	0	978,570	0	93.10	
200.00		Total (lines 50 through 199)		81,047,468	0	73,218,815	0	200.00	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0179

Period:
From 07/01/2019
To 01/31/2020Worksheet D
Part V
Date/Time Prepared:
7/28/2020 8:27 am

			Title XVIII		Hospital		PPS	
Cost Center Description			Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs		
				PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0.311621	4,844,094	0	0	1,509,521	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.515763	13,087	0	0	6,750	52.00
53.00	05300	ANESTHESIOLOGY	0.052466	1,474,463	0	0	77,359	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.195380	4,719,452	0	0	922,087	54.00
54.01	03440	BREAST HEALTH CENTER	0.000000	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.343425	3,095,626	0	0	1,063,115	55.00
56.00	05600	RADIOISOTOPE	0.182841	2,025,546	0	0	370,353	56.00
56.10	03630	ULTRASOUND	0.115150	1,373,418	0	0	158,149	56.10
57.00	05700	CT SCAN	0.028495	8,706,762	0	0	248,099	57.00
58.00	05800	MRI	0.112316	1,029,059	0	0	115,580	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.126279	1,565,745	0	0	197,721	59.00
60.00	06000	LABORATORY	0.098351	5,542,881	0	0	545,148	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.125602	525,489	0	0	66,002	65.00
65.01	03952	SLEEP LAB	0.283759	352,674	0	0	100,074	65.01
66.00	06600	PHYSICAL THERAPY	0.313789	9,839	0	0	3,087	66.00
68.00	06800	SPEECH PATHOLOGY	0.212231	12,218	0	0	2,593	68.00
69.00	06900	ELECTROCARDIOLOGY	0.147337	1,561,308	0	0	230,038	69.00
69.01	06901	C-PORT	0.000000	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.202357	98,536	0	0	19,939	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.436735	1,563,420	0	0	682,800	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.358829	813,119	0	0	291,771	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.187162	18,503,722	0	87,929	3,463,194	73.00
74.00	07400	RENAL DIALYSIS	0.291884	157,135	0	0	45,865	74.00
75.10	03340	GI LAB	0.184989	2,524,464	0	0	466,998	75.10
76.00	03951	ENTEROSTOMAL THERAPY	0.000000	0	0	0	0	76.00
76.10	03950	NEUROLOGY	0.000000	0	0	0	0	76.10
76.20	03290	EMG	0.000000	0	0	0	0	76.20
76.30	03953	OS SVCS	1.120544	199	0	0	223	76.30
76.40	03040	AUDIOLOGY	0.000000	0	0	0	0	76.40
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	0.785105	220,677	0	0	173,255	90.00
90.01	09001	PALOS DIAGNOSTIC CENTER	0.466756	130,331	0	0	60,833	90.01
90.02	09002	CARE STATIONS	0.534585	543,918	0	0	290,770	90.02
90.03	09003	OUPATIENT CARE CENTER	0.207290	3,214,208	0	0	666,273	90.03
91.00	09100	EMERGENCY	0.130957	5,953,780	0	0	779,689	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.454902	1,547,195	0	0	703,822	92.00
93.00	04951	OUTPATIENT REHAB	0.532045	117,880	0	0	62,717	93.00
93.10	04950	WOUND CARE CENTER	0.382974	978,570	0	0	374,767	93.10
200.00		Subtotal (see instructions)		73,218,815	0	87,929	13,698,592	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		73,218,815	0	87,929	13,698,592	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			Provider CCN: 14-0179		Period: From 07/01/2019 To 01/31/2020	Worksheet D Part V Date/Time Prepared: 7/28/2020 8:27 am
			Title XVIII		Hospital	PPS
Cost Center Description			Costs			
			Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0		50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	03440	BREAST HEALTH CENTER	0	0		54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0		55.00
56.00	05600	RADIOISOTOPE	0	0		56.00
56.10	03630	ULTRASOUND	0	0		56.10
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
65.01	03952	SLEEP LAB	0	0		65.01
66.00	06600	PHYSICAL THERAPY	0	0		66.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
69.01	06901	C-PORT	0	0		69.01
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	16,457		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
75.10	03340	GI LAB	0	0		75.10
76.00	03951	ENTEROSTOMAL THERAPY	0	0		76.00
76.10	03950	NEUROLOGY	0	0		76.10
76.20	03290	EMG	0	0		76.20
76.30	03953	OS SVCS	0	0		76.30
76.40	03040	AUDIOLOGY	0	0		76.40
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	PALOS DIAGNOSTIC CENTER	0	0		90.01
90.02	09002	CARE STATIONS	0	0		90.02
90.03	09003	OUTPATIENT CARE CENTER	0	0		90.03
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
93.00	04951	OUTPATIENT REHAB	0	0		93.00
93.10	04950	WOUND CARE CENTER	0	0		93.10
200.00		Subtotal (see instructions)	0	16,457		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	16,457		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0179

Period:

Worksheet D

Component CCN: 14-S179

From 07/01/2019
To 01/31/2020Part II
Date/Time Prepared:
7/28/2020 8:27 am

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	998,910	28,866,256	0.034605	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	340,441	6,140,072	0.055446	0	0	52.00
53.00	05300 ANESTHESIOLOGY	79,450	10,668,805	0.007447	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	955,797	29,368,454	0.032545	12,841	418	54.00
54.01	03440 BREAST HEALTH CENTER	0	0	0.000000	0	0	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	500,182	9,900,242	0.050522	0	0	55.00
56.00	05600 RADIOISOTOPE	69,895	7,749,467	0.009019	0	0	56.00
56.10	03630 ULTRASOUND	95,356	12,210,081	0.007810	968	8	56.10
57.00	05700 CT SCAN	52,547	59,695,621	0.000880	34,760	31	57.00
58.00	05800 MRI	49,981	7,788,184	0.006418	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	245,666	13,620,226	0.018037	0	0	59.00
60.00	06000 LABORATORY	358,067	94,714,093	0.003781	210,206	795	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	179,200	21,690,176	0.008262	80,789	667	65.00
65.01	03952 SLEEP LAB	48,747	1,191,971	0.040896	0	0	65.01
66.00	06600 PHYSICAL THERAPY	122,998	6,737,210	0.018257	1,558	28	66.00
68.00	06800 SPEECH PATHOLOGY	22,706	1,536,529	0.014777	1,227	18	68.00
69.00	06900 ELECTROCARDIOLOGY	92,280	12,398,157	0.007443	14,444	108	69.00
69.01	06901 C-PORT	0	0	0.000000	0	0	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	29,137	1,183,811	0.024613	969	24	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	195,276	14,228,360	0.013724	126	2	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	46,805	10,986,161	0.004260	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	316,254	82,821,669	0.003818	51,198	195	73.00
74.00	07400 RENAL DIALYSIS	52,422	3,616,579	0.014495	5,187	75	74.00
75.10	03340 GI LAB	332,416	12,738,806	0.026095	0	0	75.10
76.00	03951 ENTEROSTOMAL THERAPY	0	0	0.000000	0	0	76.00
76.10	03950 NEUROLOGY	0	0	0.000000	0	0	76.10
76.20	03290 EMG	0	0	0.000000	0	0	76.20
76.30	03953 OS SVCS	225	17,363	0.012959	0	0	76.30
76.40	03040 AUDIOLOGY	0	0	0.000000	0	0	76.40
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	48,303	997,477	0.048425	0	0	90.00
90.01	09001 PALOS DIAGNOSTIC CENTER	38,838	391,164	0.099288	0	0	90.01
90.02	09002 CARE STATIONS	226,094	3,636,544	0.062173	0	0	90.02
90.03	09003 OUPATIENT CARE CENTER	257,901	12,209,325	0.021123	0	0	90.03
91.00	09100 EMERGENCY	408,053	62,623,400	0.006516	97,833	637	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	9,700,661	0.000000	0	0	92.00
93.00	04951 OUTPATIENT REHAB	162,594	2,823,976	0.057576	0	0	93.00
93.10	04950 WOUND CARE CENTER	40,474	2,220,772	0.018225	0	0	93.10
200.00	Total (lines 50 through 199)	6,367,015	544,471,612		512,106	3,006	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0179 Component CCN: 14-S179		Period: From 07/01/2019 To 01/31/2020		Worksheet D Part IV Date/Time Prepared: 7/28/2020 8:27 am	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description				Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
				1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM		0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0	54.00
54.01	03440	BREAST HEALTH CENTER		0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC		0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE		0	0	0	0	0	56.00
56.10	03630	ULTRASOUND		0	0	0	0	0	56.10
57.00	05700	CT SCAN		0	0	0	0	0	57.00
58.00	05800	MRI		0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	0	0	59.00
60.00	06000	LABORATORY		0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS		0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY		0	0	0	0	0	65.00
65.01	03952	SLEEP LAB		0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	0	0	69.00
69.01	06901	C-PORT		0	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	0	0	74.00
75.10	03340	GI LAB		0	0	0	0	0	75.10
76.00	03951	ENTEROSTOMAL THERAPY		0	0	0	0	0	76.00
76.10	03950	NEUROLOGY		0	0	0	0	0	76.10
76.20	03290	EMG		0	0	0	0	0	76.20
76.30	03953	OS SVCS		0	0	0	0	0	76.30
76.40	03040	AUDIOLOGY		0	0	0	0	0	76.40
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	PALOS DIAGNOSTIC CENTER		0	0	0	0	0	90.01
90.02	09002	CARE STATIONS		0	0	0	0	0	90.02
90.03	09003	OUTPATIENT CARE CENTER		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
93.00	04951	OUTPATIENT REHAB		0	0	0	0	0	93.00
93.10	04950	WOUND CARE CENTER		0	0	0	0	0	93.10
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: 14-0179 Component CCN: 14-S179		Period: From 07/01/2019 To 01/31/2020		Worksheet D Part IV Date/Time Prepared: 7/28/2020 8:27 am	
			Title XVIII		Subprovider - IPF		PPS	
Cost Center Description			All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
			4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	28,866,256	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	6,140,072	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	10,668,805	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	29,368,454	0.000000	54.00
54.01	03440	BREAST HEALTH CENTER	0	0	0	0	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	9,900,242	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	7,749,467	0.000000	56.00
56.10	03630	ULTRASOUND	0	0	0	12,210,081	0.000000	56.10
57.00	05700	CT SCAN	0	0	0	59,695,621	0.000000	57.00
58.00	05800	MRI	0	0	0	7,788,184	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	13,620,226	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	94,714,093	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	21,690,176	0.000000	65.00
65.01	03952	SLEEP LAB	0	0	0	1,191,971	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	6,737,210	0.000000	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,536,529	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	12,398,157	0.000000	69.00
69.01	06901	C-PORT	0	0	0	0	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	1,183,811	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	14,228,360	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	10,986,161	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	82,821,669	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	3,616,579	0.000000	74.00
75.10	03340	GI LAB	0	0	0	12,738,806	0.000000	75.10
76.00	03951	ENTEROSTOMAL THERAPY	0	0	0	0	0.000000	76.00
76.10	03950	NEUROLOGY	0	0	0	0	0.000000	76.10
76.20	03290	EMG	0	0	0	0	0.000000	76.20
76.30	03953	OS SVCS	0	0	0	17,363	0.000000	76.30
76.40	03040	AUDIOLOGY	0	0	0	0	0.000000	76.40
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	997,477	0.000000	90.00
90.01	09001	PALOS DIAGNOSTIC CENTER	0	0	0	391,164	0.000000	90.01
90.02	09002	CARE STATIONS	0	0	0	3,636,544	0.000000	90.02
90.03	09003	OUTPATIENT CARE CENTER	0	0	0	12,209,325	0.000000	90.03
91.00	09100	EMERGENCY	0	0	0	62,623,400	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	9,700,661	0.000000	92.00
93.00	04951	OUTPATIENT REHAB	0	0	0	2,823,976	0.000000	93.00
93.10	04950	WOUND CARE CENTER	0	0	0	2,220,772	0.000000	93.10
200.00		Total (lines 50 through 199)	0	0	0	544,471,612		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS				Provider CCN: 14-0179 Component CCN: 14-S179		Period: From 07/01/2019 To 01/31/2020		Worksheet D Part IV Date/Time Prepared: 7/28/2020 8:27 am	
				Title XVIII		Subprovider - IPF		PPS	
Cost Center Description				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	12,841	0	0	0	0	54.00
54.01	03440	BREAST HEALTH CENTER	0.000000	0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	0	56.00
56.10	03630	ULTRASOUND	0.000000	968	0	0	0	0	56.10
57.00	05700	CT SCAN	0.000000	34,760	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	210,206	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.000000	80,789	0	0	0	0	65.00
65.01	03952	SLEEP LAB	0.000000	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.000000	1,558	0	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0.000000	1,227	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	14,444	0	0	0	0	69.00
69.01	06901	C-PORT	0.000000	0	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	969	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	126	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	51,198	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	5,187	0	0	0	0	74.00
75.10	03340	GI LAB	0.000000	0	0	0	0	0	75.10
76.00	03951	ENTEROSTOMAL THERAPY	0.000000	0	0	0	0	0	76.00
76.10	03950	NEUROLOGY	0.000000	0	0	0	0	0	76.10
76.20	03290	EMG	0.000000	0	0	0	0	0	76.20
76.30	03953	OS SVCS	0.000000	0	0	0	0	0	76.30
76.40	03040	AUDIOLOGY	0.000000	0	0	0	0	0	76.40
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0.000000	0	0	0	0	0	90.00
90.01	09001	PALOS DIAGNOSTIC CENTER	0.000000	0	0	0	0	0	90.01
90.02	09002	CARE STATIONS	0.000000	0	0	0	0	0	90.02
90.03	09003	OUTPATIENT CARE CENTER	0.000000	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.000000	97,833	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	0	92.00
93.00	04951	OUTPATIENT REHAB	0.000000	0	0	0	0	0	93.00
93.10	04950	WOUND CARE CENTER	0.000000	0	0	0	0	0	93.10
200.00		Total (lines 50 through 199)			512,106	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0179

Period:

Worksheet D

Component CCN: 14-S179

From 07/01/2019
To 01/31/2020Part V
Date/Time Prepared:
7/28/2020 8:27 am

Title XVIII

Subprovider -
IPF

PPS

Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs	
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)
		1.00	2.00	3.00	4.00	5.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0.311621	0	0	0	0 50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.515763	0	0	0	0 52.00
53.00	05300 ANESTHESIOLOGY	0.052466	0	0	0	0 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.195380	0	0	0	0 54.00
54.01	03440 BREAST HEALTH CENTER	0.000000	0	0	0	0 54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0.343425	0	0	0	0 55.00
56.00	05600 RADIOISOTOPE	0.182841	0	0	0	0 56.00
56.10	03630 ULTRASOUND	0.115150	0	0	0	0 56.10
57.00	05700 CT SCAN	0.028495	0	0	0	0 57.00
58.00	05800 MRI	0.112316	0	0	0	0 58.00
59.00	05900 CARDIAC CATHETERIZATION	0.126279	0	0	0	0 59.00
60.00	06000 LABORATORY	0.098351	0	0	0	0 60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0 62.30
65.00	06500 RESPIRATORY THERAPY	0.125602	0	0	0	0 65.00
65.01	03952 SLEEP LAB	0.283759	0	0	0	0 65.01
66.00	06600 PHYSICAL THERAPY	0.313789	0	0	0	0 66.00
68.00	06800 SPEECH PATHOLOGY	0.212231	0	0	0	0 68.00
69.00	06900 ELECTROCARDIOLOGY	0.147337	0	0	0	0 69.00
69.01	06901 C-PORT	0.000000	0	0	0	0 69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0.202357	0	0	0	0 70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.436735	0	0	0	0 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.358829	0	0	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.187162	0	0	0	0 73.00
74.00	07400 RENAL DIALYSIS	0.291884	0	0	0	0 74.00
75.10	03340 GI LAB	0.184989	0	0	0	0 75.10
76.00	03951 ENTEROSTOMAL THERAPY	0.000000	0	0	0	0 76.00
76.10	03950 NEUROLOGY	0.000000	0	0	0	0 76.10
76.20	03290 EMG	0.000000	0	0	0	0 76.20
76.30	03953 OS SVCS	1.120544	0	0	0	0 76.30
76.40	03040 AUDIOLOGY	0.000000	0	0	0	0 76.40
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	0.785105	0	0	0	0 90.00
90.01	09001 PALOS DIAGNOSTIC CENTER	0.466756	0	0	0	0 90.01
90.02	09002 CARE STATIONS	0.534585	0	0	0	0 90.02
90.03	09003 OUPATIENT CARE CENTER	0.207290	0	0	0	0 90.03
91.00	09100 EMERGENCY	0.130957	0	0	0	0 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.454902	0	0	0	0 92.00
93.00	04951 OUTPATIENT REHAB	0.532045	0	0	0	0 93.00
93.10	04950 WOUND CARE CENTER	0.382974	0	0	0	0 93.10
200.00	Subtotal (see instructions)		0	0	0	0 200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	0 201.00
202.00	Net Charges (line 200 - line 201)		0	0	0	0 202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0179

Period:

Worksheet D

Component CCN: 14-S179

From 07/01/2019
To 01/31/2020Part V
Date/Time Prepared:
7/28/2020 8:27 am

Title XVIII

Subprovider -
IPF

PPS

	Cost Center Description	Costs			
		Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
		6.00	7.00		
	ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01	03440	BREAST HEALTH CENTER	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
56.00	05600	RADIOISOTOPE	0	0	56.00
56.10	03630	ULTRASOUND	0	0	56.10
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
65.01	03952	SLEEP LAB	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
69.01	06901	C-PORT	0	0	69.01
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
74.00	07400	RENAL DIALYSIS	0	0	74.00
75.10	03340	GI LAB	0	0	75.10
76.00	03951	ENTEROSTOMAL THERAPY	0	0	76.00
76.10	03950	NEUROLOGY	0	0	76.10
76.20	03290	EMG	0	0	76.20
76.30	03953	OS SVCS	0	0	76.30
76.40	03040	AUDIOLOGY	0	0	76.40
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	PALOS DIAGNOSTIC CENTER	0	0	90.01
90.02	09002	CARE STATIONS	0	0	90.02
90.03	09003	OUTPATIENT CARE CENTER	0	0	90.03
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
93.00	04951	OUTPATIENT REHAB	0	0	93.00
93.10	04950	WOUND CARE CENTER	0	0	93.10
200.00		Subtotal (see instructions)	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	0	0	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0179

Period:
From 07/01/2019
To 01/31/2020Worksheet D
Part I
Date/Time Prepared:
7/28/2020 8:27 am

			Title XIX		Hospital	Cost		
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)		
		1.00	2.00	3.00	4.00	5.00		
	INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	2,359,514	0	2,359,514	32,707	72.14	30.00	
31.00	INTENSIVE CARE UNIT	302,829		302,829	2,709	111.79	31.00	
34.10	NICU	261,124		261,124	867	301.18	34.10	
40.00	SUBPROVIDER - IPF	213,998	0	213,998	1,227	174.41	40.00	
43.00	NURSERY	34,911		34,911	1,039	33.60	43.00	
200.00	Total (lines 30 through 199)	3,172,376		3,172,376	38,549		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	1,325	95,586					30.00
31.00	INTENSIVE CARE UNIT	0	0					31.00
34.10	NICU	603	181,612					34.10
40.00	SUBPROVIDER - IPF	0	0					40.00
43.00	NURSERY	216	7,258					43.00
200.00	Total (lines 30 through 199)	2,144	284,456					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0179

Period:
From 07/01/2019
To 01/31/2020Worksheet D
Part II
Date/Time Prepared:
7/28/2020 8:27 am

Cost Center Description		Title XIX		Hospital		Cost	
		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	998,910	0	0.000000	0	0 50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	340,441	0	0.000000	0	0 52.00
53.00	05300	ANESTHESIOLOGY	79,450	0	0.000000	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	955,797	0	0.000000	0	0 54.00
54.01	03440	BREAST HEALTH CENTER	0	0	0.000000	0	0 54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	500,182	0	0.000000	0	0 55.00
56.00	05600	RADIOISOTOPE	69,895	0	0.000000	0	0 56.00
56.10	03630	ULTRASOUND	95,356	0	0.000000	0	0 56.10
57.00	05700	CT SCAN	52,547	0	0.000000	0	0 57.00
58.00	05800	MRI	49,981	0	0.000000	0	0 58.00
59.00	05900	CARDIAC CATHETERIZATION	245,666	0	0.000000	0	0 59.00
60.00	06000	LABORATORY	358,067	0	0.000000	0	0 60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0 62.30
65.00	06500	RESPIRATORY THERAPY	179,200	0	0.000000	0	0 65.00
65.01	03952	SLEEP LAB	48,747	0	0.000000	0	0 65.01
66.00	06600	PHYSICAL THERAPY	122,998	0	0.000000	0	0 66.00
68.00	06800	SPEECH PATHOLOGY	22,706	0	0.000000	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	92,280	0	0.000000	0	0 69.00
69.01	06901	C-PORT	0	0	0.000000	0	0 69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	29,137	0	0.000000	0	0 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	195,276	0	0.000000	0	0 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	46,805	0	0.000000	0	0 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	316,254	0	0.000000	0	0 73.00
74.00	07400	RENAL DIALYSIS	52,422	0	0.000000	0	0 74.00
75.10	03340	GI LAB	332,416	0	0.000000	0	0 75.10
76.00	03951	ENTEROSTOMAL THERAPY	0	0	0.000000	0	0 76.00
76.10	03950	NEUROLOGY	0	0	0.000000	0	0 76.10
76.20	03290	EMG	0	0	0.000000	0	0 76.20
76.30	03953	OS SVCS	225	0	0.000000	0	0 76.30
76.40	03040	AUDIOLOGY	0	0	0.000000	0	0 76.40
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	48,303	0	0.000000	0	0 90.00
90.01	09001	PALOS DIAGNOSTIC CENTER	38,838	0	0.000000	0	0 90.01
90.02	09002	CARE STATIONS	226,094	0	0.000000	0	0 90.02
90.03	09003	OUTPATIENT CARE CENTER	257,901	0	0.000000	0	0 90.03
91.00	09100	EMERGENCY	408,053	0	0.000000	0	0 91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	348,873	0	0.000000	0	0 92.00
93.00	04951	OUTPATIENT REHAB	162,594	0	0.000000	0	0 93.00
93.10	04950	WOUND CARE CENTER	40,474	0	0.000000	0	0 93.10
200.00		Total (lines 50 through 199)	6,715,888	0		0	0 200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS					Provider CCN: 14-0179		Period: From 07/01/2019 To 01/31/2020		Worksheet D Part III Date/Time Prepared: 7/28/2020 8:27 am		
					Title XIX		Hospital		Cost		
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		
34.10	02060	NICU	0	0	0	0	0	0	34.10		
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	32,707	0.00	1,325		30.00		
31.00	03100	INTENSIVE CARE UNIT	0	0	2,709	0.00	0		31.00		
34.10	02060	NICU	0	0	867	0.00	603		34.10		
40.00	04000	SUBPROVIDER - IPF	0	0	1,227	0.00	0		40.00		
43.00	04300	NURSERY	0	0	1,039	0.00	216		43.00		
200.00	Total (lines 30 through 199)		0	0	38,549		2,144		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
34.10	02060	NICU	0								34.10
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: 14-0179		Period: From 07/01/2019 To 01/31/2020		Worksheet D Part IV Date/Time Prepared: 7/28/2020 8:27 am	
				Title XIX		Hospital		Cost	
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
52.00	05200	DELIVERY ROOM & LABOR ROOM		0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		0	0	0	0	0	54.00
54.01	03440	BREAST HEALTH CENTER		0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC		0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE		0	0	0	0	0	56.00
56.10	03630	ULTRASOUND		0	0	0	0	0	56.10
57.00	05700	CT SCAN		0	0	0	0	0	57.00
58.00	05800	MRI		0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	0	0	59.00
60.00	06000	LABORATORY		0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS		0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY		0	0	0	0	0	65.00
65.01	03952	SLEEP LAB		0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY		0	0	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY		0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		0	0	0	0	0	69.00
69.01	06901	C-PORT		0	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY		0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS		0	0	0	0	0	74.00
75.10	03340	GI LAB		0	0	0	0	0	75.10
76.00	03951	ENTEROSTOMAL THERAPY		0	0	0	0	0	76.00
76.10	03950	NEUROLOGY		0	0	0	0	0	76.10
76.20	03290	EMG		0	0	0	0	0	76.20
76.30	03953	OS SVCS		0	0	0	0	0	76.30
76.40	03040	AUDIOLOGY		0	0	0	0	0	76.40
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	PALOS DIAGNOSTIC CENTER		0	0	0	0	0	90.01
90.02	09002	CARE STATIONS		0	0	0	0	0	90.02
90.03	09003	OUTPATIENT CARE CENTER		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
93.00	04951	OUTPATIENT REHAB		0	0	0	0	0	93.00
93.10	04950	WOUND CARE CENTER		0	0	0	0	0	93.10
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: 14-0179		Period: From 07/01/2019 To 01/31/2020		Worksheet D Part IV Date/Time Prepared: 7/28/2020 8:27 am	
				Title XIX		Hospital		Cost	
Cost Center Description				All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7) (see instructions)	
				4.00	5.00	6.00	7.00	8.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0	0	0	0	0	0.000000	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0.000000	54.00
54.01	03440	BREAST HEALTH CENTER	0	0	0	0	0	0.000000	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	0.000000	55.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	0.000000	56.00
56.10	03630	ULTRASOUND	0	0	0	0	0	0.000000	56.10
57.00	05700	CT SCAN	0	0	0	0	0	0.000000	57.00
58.00	05800	MRI	0	0	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	0	0	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0.000000	65.00
65.01	03952	SLEEP LAB	0	0	0	0	0	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0.000000	66.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	0.000000	69.00
69.01	06901	C-PORT	0	0	0	0	0	0.000000	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	0.000000	74.00
75.10	03340	GI LAB	0	0	0	0	0	0.000000	75.10
76.00	03951	ENTEROSTOMAL THERAPY	0	0	0	0	0	0.000000	76.00
76.10	03950	NEUROLOGY	0	0	0	0	0	0.000000	76.10
76.20	03290	EMG	0	0	0	0	0	0.000000	76.20
76.30	03953	OS SVCS	0	0	0	0	0	0.000000	76.30
76.40	03040	AUDIOLOGY	0	0	0	0	0	0.000000	76.40
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	0.000000	76.99
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0	0	0	0	0.000000	90.00
90.01	09001	PALOS DIAGNOSTIC CENTER	0	0	0	0	0	0.000000	90.01
90.02	09002	CARE STATIONS	0	0	0	0	0	0.000000	90.02
90.03	09003	OUTPATIENT CARE CENTER	0	0	0	0	0	0.000000	90.03
91.00	09100	EMERGENCY	0	0	0	0	0	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	0.000000	92.00
93.00	04951	OUTPATIENT REHAB	0	0	0	0	0	0.000000	93.00
93.10	04950	WOUND CARE CENTER	0	0	0	0	0	0.000000	93.10
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: 14-0179		Period: From 07/01/2019 To 01/31/2020		Worksheet D Part IV Date/Time Prepared: 7/28/2020 8:27 am	
Cost Center Description				Title XIX		Hospital		Cost	
				Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
				9.00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	0	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	0	54.00
54.01	03440	BREAST HEALTH CENTER	0.000000	0	0	0	0	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	0	55.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	0	56.00
56.10	03630	ULTRASOUND	0.000000	0	0	0	0	0	56.10
57.00	05700	CT SCAN	0.000000	0	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	0	65.00
65.01	03952	SLEEP LAB	0.000000	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	0	66.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	0	69.00
69.01	06901	C-PORT	0.000000	0	0	0	0	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	0	74.00
75.10	03340	GI LAB	0.000000	0	0	0	0	0	75.10
76.00	03951	ENTEROSTOMAL THERAPY	0.000000	0	0	0	0	0	76.00
76.10	03950	NEUROLOGY	0.000000	0	0	0	0	0	76.10
76.20	03290	EMG	0.000000	0	0	0	0	0	76.20
76.30	03953	OS SVCS	0.000000	0	0	0	0	0	76.30
76.40	03040	AUDIOLOGY	0.000000	0	0	0	0	0	76.40
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	0	76.99
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0.000000	0	0	0	0	0	90.00
90.01	09001	PALOS DIAGNOSTIC CENTER	0.000000	0	0	0	0	0	90.01
90.02	09002	CARE STATIONS	0.000000	0	0	0	0	0	90.02
90.03	09003	OUTPATIENT CARE CENTER	0.000000	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.000000	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	0	92.00
93.00	04951	OUTPATIENT REHAB	0.000000	0	0	0	0	0	93.00
93.10	04950	WOUND CARE CENTER	0.000000	0	0	0	0	0	93.10
200.00		Total (lines 50 through 199)		0	0	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0179	Period: From 07/01/2019 To 01/31/2020	Worksheet D-1 Date/Time Prepared: 7/28/2020 8:27 am
		Title XVIII	Hospital	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		32,707	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		32,707	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)		27,871	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)		10,216	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)		29,845,111	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)		29,845,111	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)		29,845,111	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)		912.50	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		9,322,100	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		9,322,100	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0179

Period:
From 07/01/2019
To 01/31/2020

Worksheet D-1

Date/Time Prepared:
7/28/2020 8:27 am

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	4,962,170	2,709	1,831.73	886	1,622,913
44.00	CORONARY CARE UNIT					
45.00	BURN INTENSIVE CARE UNIT					
46.00	SURGICAL INTENSIVE CARE UNIT					
46.10	NICU	1,925,509	867	2,220.89	0	0
47.00	OTHER SPECIAL CARE (SPECIFY)					
	Cost Center Description					
						1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					13,680,780
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					24,625,793
	PASS THROUGH COST ADJUSTMENTS					
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					836,028
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					801,886
52.00	Total Program excludable cost (sum of lines 50 and 51)					1,637,914
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					22,987,879
	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)					4,836
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					912.50
89.00	Observation bed cost (line 87 x line 88) (see instructions)					4,412,850

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0179

Period:
From 07/01/2019
To 01/31/2020

Worksheet D-1

Date/Time Prepared:
7/28/2020 8:27 am

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	2,359,514	29,845,111	0.079059	4,412,850	348,876
91.00	Nursing School cost	0	29,845,111	0.000000	4,412,850	0
92.00	Allied health cost	0	29,845,111	0.000000	4,412,850	0
93.00	All other Medical Education	0	29,845,111	0.000000	4,412,850	0

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0179 Component CCN: 14-S179	Period: From 07/01/2019 To 01/31/2020	Worksheet D-1 Date/Time Prepared: 7/28/2020 8:27 am
		Title XVIII	Subprovider - IPF	PPS
Cost Center Description			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		1,227	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		1,227	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)		1,227	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)		322	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)		1,815,974	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)		1,815,974	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)		1,815,974	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)		1,480.01	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		476,563	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)		476,563	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0179	Period: From 07/01/2019 To 01/31/2020	Worksheet D-1	
				Component CCN: 14-S179		Date/Time Prepared: 7/28/2020 8:27 am	
				Title XVIII		Subprovider - IPF	PPS
Cost Center Description		Total	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)	
		Inpatient Cost	Inpatient Days	Diem (col. 1 ÷ col. 2)			
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
46.10	NICU	0	0	0.00	0	0	46.10
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)					61,546	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					538,109	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)					56,160	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					3,006	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					59,166	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					478,943	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0179 Component CCN: 14-S179		Period: From 07/01/2019 To 01/31/2020		Worksheet D-1 Date/Time Prepared: 7/28/2020 8:27 am	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description		Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	213,998	1,815,974	0.117842	0	0	90.00
91.00	Nursing School cost	0	1,815,974	0.000000	0	0	91.00
92.00	Allied health cost	0	1,815,974	0.000000	0	0	92.00
93.00	All other Medical Education	0	1,815,974	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0179	Period: From 07/01/2019 To 01/31/2020	Worksheet D-1 Date/Time Prepared: 7/28/2020 8:27 am
Cost Center Description		Title XIX	Hospital	Cost
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		32,707	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		32,707	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)		27,871	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)		1,325	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		1,039	15.00
16.00	Nursery days (title V or XIX only)		216	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)		29,984,034	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)		29,984,034	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)		29,984,034	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)		916.75	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,214,694	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)		1,214,694	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0179

Period:
From 07/01/2019
To 01/31/2020

Worksheet D-1

Date/Time Prepared:
7/28/2020 8:27 am

			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)	901,133	1,039	867.31	216	187,339	42.00	
	Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	4,948,937	2,709	1,826.85	0	0	43.00	
44.00	CORONARY CARE UNIT						44.00	
45.00	BURN INTENSIVE CARE UNIT						45.00	
46.00	SURGICAL INTENSIVE CARE UNIT						46.00	
46.10	NICU	1,925,509	867	2,220.89	603	1,339,197	46.10	
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00	
	Cost Center Description							
						1.00		
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						2,741,230	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)						4,836	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						916.75	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)						4,433,403	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0179

Period:
From 07/01/2019
To 01/31/2020

Worksheet D-1

Date/Time Prepared:
7/28/2020 8:27 am

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	2,359,514	29,984,034	0.078692	4,433,403	348,873	90.00
91.00	Nursing School cost	0	29,984,034	0.000000	4,433,403	0	91.00
92.00	Allied health cost	0	29,984,034	0.000000	4,433,403	0	92.00
93.00	All other Medical Education	0	29,984,034	0.000000	4,433,403	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0179	Period: From 07/01/2019 To 01/31/2020	Worksheet D-3 Date/Time Prepared: 7/28/2020 8:27 am	
Cost Center Description		Title XVIII	Hospital	PPS	
		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		26,734,181	30.00
31.00	03100	INTENSIVE CARE UNIT		3,519,924	31.00
34.10	02060	NICU		0	34.10
40.00	04000	SUBPROVIDER - IPF		0	40.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.311621	4,800,661	50.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.515763	5,109	52.00
53.00	05300	ANESTHESIOLOGY	0.052466	1,496,921	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.195380	4,041,495	54.00
54.01	03440	BREAST HEALTH CENTER	0.000000	0	54.01
55.00	05500	RADIOLOGY-THERAPEUTIC	0.343425	134,280	55.00
56.00	05600	RADIOISOTOPE	0.182841	1,021,521	56.00
56.10	03630	ULTRASOUND	0.115150	1,527,304	56.10
57.00	05700	CT SCAN	0.028495	8,107,474	57.00
58.00	05800	MRI	0.112316	1,209,471	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.135768	2,636,756	59.00
60.00	06000	LABORATORY	0.098351	14,294,834	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.126224	6,700,951	65.00
65.01	03952	SLEEP LAB	0.283759	0	65.01
66.00	06600	PHYSICAL THERAPY	0.313789	1,008,928	66.00
68.00	06800	SPEECH PATHOLOGY	0.212231	488,429	68.00
69.00	06900	ELECTROCARDIOLOGY	0.148776	2,702,673	69.00
69.01	06901	C-PORT	0.000000	0	69.01
70.00	07000	ELECTROENCEPHALOGRAPHY	0.202357	131,139	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.436735	3,556,003	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.358829	2,840,087	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.187162	12,888,963	73.00
74.00	07400	RENAL DIALYSIS	0.293253	1,588,802	74.00
75.10	03340	GI LAB	0.184989	1,121,304	75.10
76.00	03951	ENTEROSTOMAL THERAPY	0.000000	0	76.00
76.10	03950	NEUROLOGY	0.000000	0	76.10
76.20	03290	EMG	0.000000	0	76.20
76.30	03953	OS SVCS	1.120544	4,533	76.30
76.40	03040	AUDIOLOGY	0.000000	0	76.40
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	0.785105	18,784	90.00
90.01	09001	PALOS DIAGNOSTIC CENTER	0.466756	0	90.01
90.02	09002	CARE STATIONS	0.537791	8,211	90.02
90.03	09003	OUTPATIENT CARE CENTER	0.207290	4,837	90.03
91.00	09100	EMERGENCY	0.130957	7,916,572	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.454902	785,868	92.00
93.00	04951	OUTPATIENT REHAB	0.534039	2,308	93.00
93.10	04950	WOUND CARE CENTER	0.386368	3,250	93.10
200.00		Total (sum of lines 50 through 94 and 96 through 98)		81,047,468	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)		81,047,468	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0179 Component CCN: 14-S179	Period: From 07/01/2019 To 01/31/2020	Worksheet D-3 Date/Time Prepared: 7/28/2020 8:27 am	
		Title XVIII	Subprovider - IPF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		0		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
34.10	02060 NICU		0		34.10
40.00	04000 SUBPROVIDER - IPF		694,702		40.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.311621	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.515763	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.052466	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.195380	12,841	2,509	54.00
54.01	03440 BREAST HEALTH CENTER	0.000000	0	0	54.01
55.00	05500 RADIOLOGY-THERAPEUTIC	0.343425	0	0	55.00
56.00	05600 RADIOISOTOPE	0.182841	0	0	56.00
56.10	03630 ULTRASOUND	0.115150	968	111	56.10
57.00	05700 CT SCAN	0.028495	34,760	990	57.00
58.00	05800 MRI	0.112316	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.135768	0	0	59.00
60.00	06000 LABORATORY	0.098351	210,206	20,674	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0.126224	80,789	10,198	65.00
65.01	03952 SLEEP LAB	0.283759	0	0	65.01
66.00	06600 PHYSICAL THERAPY	0.313789	1,558	489	66.00
68.00	06800 SPEECH PATHOLOGY	0.212231	1,227	260	68.00
69.00	06900 ELECTROCARDIOLOGY	0.148776	14,444	2,149	69.00
69.01	06901 C-PORT	0.000000	0	0	69.01
70.00	07000 ELECTROENCEPHALOGRAPHY	0.202357	969	196	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.436735	126	55	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.358829	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.187162	51,198	9,582	73.00
74.00	07400 RENAL DIALYSIS	0.293253	5,187	1,521	74.00
75.10	03340 GI LAB	0.184989	0	0	75.10
76.00	03951 ENTEROSTOMAL THERAPY	0.000000	0	0	76.00
76.10	03950 NEUROLOGY	0.000000	0	0	76.10
76.20	03290 EMG	0.000000	0	0	76.20
76.30	03953 OS SVCS	1.120544	0	0	76.30
76.40	03040 AUDIOLOGY	0.000000	0	0	76.40
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	0.785105	0	0	90.00
90.01	09001 PALOS DIAGNOSTIC CENTER	0.466756	0	0	90.01
90.02	09002 CARE STATIONS	0.537791	0	0	90.02
90.03	09003 OUTPATIENT CARE CENTER	0.207290	0	0	90.03
91.00	09100 EMERGENCY	0.130957	97,833	12,812	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.454902	0	0	92.00
93.00	04951 OUTPATIENT REHAB	0.534039	0	0	93.00
93.10	04950 WOUND CARE CENTER	0.386368	0	0	93.10
200.00	Total (sum of lines 50 through 94 and 96 through 98)		512,106	61,546	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)		512,106		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0179

Period:
From 07/01/2019
To 01/31/2020Worksheet E
Part A
Date/Time Prepared:
7/28/2020 8:27 am

		Title XVIII	Hospital	PPS	
				1.00	
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS					
1.00	DRG Amounts Other than Outlier Payments			0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)			8,564,068	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)			11,442,090	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)			24,587	2.03
2.04	Outlier payments for discharges occurring on or after October 1 (see instructions)			73,763	2.04
3.00	Managed Care Simulated Payments			9,039,082	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)			197.51	4.00
Indirect Medical Education Adjustment					
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)			3.99	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)			0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)			0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.			0.25	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).			0.16	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)			3.90	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records			1.81	10.00
11.00	FTE count for residents in dental and podiatric programs.			0.00	11.00
12.00	Current year allowable FTE (see instructions)			1.81	12.00
13.00	Total allowable FTE count for the prior year.			2.90	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.			2.24	14.00
15.00	Sum of lines 12 through 14 divided by 3.			2.32	15.00
16.00	Adjustment for residents in initial years of the program			0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure			0.00	17.00
18.00	Adjusted rolling average FTE count			2.32	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).			0.011746	19.00
20.00	Prior year resident to bed ratio (see instructions)			0.014363	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)			0.011746	21.00
22.00	IME payment adjustment (see instructions)			128,039	22.00
22.01	IME payment adjustment - Managed Care (see instructions)			57,850	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)			-2.09	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)			128,039	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			57,850	29.01
Disproportionate Share Adjustment					
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)			6.21	30.00
31.00	Percentage of Medicaid patient days (see instructions)			22.25	31.00
32.00	Sum of lines 30 and 31			28.46	32.00
33.00	Allowable disproportionate share percentage (see instructions)			12.69	33.00
34.00	Disproportionate share adjustment (see instructions)			634,695	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0179	Period: From 07/01/2019 To 01/31/2020	Worksheet E Part A Date/Time Prepared: 7/28/2020 8:27 am	
		Title XVIII	Hospital	PPS	
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)		8,666,366,761	8,350,599,096	35.00
35.01	Factor 3 (see instructions)		0.000327358	0.000334520	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		2,837,004	2,793,442	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		715,081	938,781	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		1,653,862		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)		22,521,104		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)			22,578,954	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)			1,625,524	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).			100,999	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)			24,305,477	59.00
60.00	Primary payer payments			0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)			24,305,477	61.00
62.00	Deductibles billed to program beneficiaries			1,993,552	62.00
63.00	Coinsurance billed to program beneficiaries			140,415	63.00
64.00	Allowable bad debts (see instructions)			567,819	64.00
65.00	Adjusted reimbursable bad debts (see instructions)			369,082	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			83,395	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			22,540,592	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	IME REIMBURSEMENT			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)			66,719	70.93
70.94	HRR adjustment amount (see instructions)			-267,539	70.94
70.95	Recovery of accelerated depreciation			0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0179	Period: From 07/01/2019 To 01/31/2020	Worksheet E Part A Date/Time Prepared: 7/28/2020 8:27 am
		Title XVIII	Hospital	PPS
		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		240,036	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		22,099,736	71.00
71.01	Sequestration adjustment (see instructions)		441,995	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
71.03	Sequestration adjustment-PARHM pass-throughs		0	71.03
72.00	Interim payments		21,414,474	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)		243,267	74.00
74.01	Balance due provider/program-PARHM (see instructions)		0	74.01
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		1,052,588	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

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0179

Period:
From 07/01/2019
To 01/31/2020Worksheet E
Part A Exhibit 5
Date/Time Prepared:
7/28/2020 8:27 am

		Title XVIII		Hospital		PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	8,564,068	8,564,068		8,564,068	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	11,442,090		11,442,090	11,442,090	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	24,587	24,587		24,587	2.02
2.03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2.04	73,763		73,763	73,763	2.03
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	9,039,082	3,873,892	5,165,190	9,039,082	4.00
Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.011746	0.011746	0.011746		5.00
6.00	IME payment adjustment (see instructions)	22.00	128,039	54,810	73,229	128,039	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	57,850	24,793	33,057	57,850	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	128,039	54,810	73,229	128,039	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	57,850	24,793	33,057	57,850	9.01
Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.1269	0.1269	0.1269		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	634,695	271,695	363,000	634,695	11.00
11.01	Uncompensated care payments	36.00	1,653,862	715,081	938,781	1,653,862	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	22,521,104	9,630,241	12,890,863	22,521,104	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	22,578,954	9,655,034	12,923,920	22,578,954	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	1,625,524	712,298	913,226	1,625,524	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			10,367,332	13,837,146	24,204,478	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

Provider CCN: 14-0179

Period:
From 07/01/2019
To 01/31/2020Worksheet E
Part A Exhibit 5
Date/Time Prepared:
7/28/2020 8:27 am

		Title XVIII		Hospital		PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	1,608,811	704,000	904,811	1,608,811	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	9,634	5,200	4,434	9,634	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	0.0044	0.0044	0.0044		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	7,079	3,098	3,981	7,079	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0000	0.0000	0.0000		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	0	0	0	0	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1,625,524	712,298	913,226	1,625,524	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	66,719	28,594	38,125	66,719	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	-267,539	-152,879	-114,660	-267,539	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		102,430	137,606	240,036	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		Y				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0179	Period: From 07/01/2019 To 01/31/2020	Worksheet E Part B Date/Time Prepared: 7/28/2020 8:27 am
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		16,457	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		13,698,592	2.00
3.00	OPPS payments		10,638,585	3.00
4.00	Outlier payment (see instructions)		14,449	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)		16,457	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		87,929	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)		87,929	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)		87,929	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		71,472	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)		16,457	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)		10,653,034	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)		2,028,789	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)		8,640,702	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		55,047	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)		8,695,749	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		8,695,749	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)		325,936	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		211,858	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		54,710	36.00
37.00	Subtotal (see instructions)		8,907,607	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)		8,907,607	40.00
40.01	Sequestration adjustment (see instructions)		178,152	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		8,707,787	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)		21,668	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: 14-0179 Component CCN: 14-S179	Period: From 07/01/2019 To 01/31/2020	Worksheet E Part B Date/Time Prepared: 7/28/2020 8:27 am
		Title XVIII	Subprovider - IPF	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	OPPS payments		0	3.00
4.00	Outlier payment (see instructions)		0	4.00
4.01	Outlier reconciliation amount (see instructions)		0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		0	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (see instructions)		0	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)		0	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)		0	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		0	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		0	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		0	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		0	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		39.50	
39.97	Demonstration payment adjustment amount before sequestration		0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		0	40.00
40.01	Sequestration adjustment (see instructions)		0	40.01
40.02	Demonstration payment adjustment amount after sequestration		0	40.02
40.03	Sequestration adjustment-PARHM pass-throughs		40.03	
41.00	Interim payments		0	41.00
41.01	Interim payments-PARHM		41.01	
42.00	Tentative settlement (for contractors use only)		0	42.00
42.01	Tentative settlement-PARHM (for contractor use only)		42.01	
43.00	Balance due provider/program (see instructions)		0	43.00
43.01	Balance due provider/program-PARHM (see instructions)		43.01	
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0179

Period:
From 07/01/2019
To 01/31/2020Worksheet E-1
Part I
Date/Time Prepared:
7/28/2020 8:27 am

		Title XVIII		Hospital		PPS
		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		21,658,463		9,019,552	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	02/28/2020	243,989	02/28/2020	311,765	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)		-243,989		-311,765	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		21,414,474		8,707,787	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		243,267		21,668	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		21,657,741		8,729,455	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: 14-0179

Period:

Worksheet E-1

Component CCN: 14-S179

From 07/01/2019
To 01/31/2020Part I
Date/Time Prepared:
7/28/2020 8:27 am

Title XVIII

Subprovider -
IPF

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		264,512		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		264,512		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		32,518		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		297,030		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
				1.00	2.00	
8.00	Name of Contractor		0			8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

Provider CCN: 14-0179

Period:
From 07/01/2019
To 01/31/2020Worksheet E-1
Part II
Date/Time Prepared:
7/28/2020 8:27 am

Title XVIII

Hospital

PPS

1.00

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0179 Component CCN: 14-S179	Period: From 07/01/2019 To 01/31/2020	Worksheet E-3 Part II Date/Time Prepared: 7/28/2020 8:27 am
		Title XVIII	Subprovider - IPF	PPS
				1.00
PART II - MEDICARE PART A SERVICES - IPF PPS				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)		309,440	1.00
2.00	Net IPF PPS Outlier Payments		0	2.00
3.00	Net IPF PPS ECT Payments		0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)		0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)		0.00	4.01
5.00	New Teaching program adjustment. (see instructions)		0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)		0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)		0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)		0.00	8.00
9.00	Average Daily Census (see instructions)		5.706977	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)		309,440	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)		309,440	16.00
17.00	Primary payer payments		0	17.00
18.00	Subtotal (line 16 less line 17).		309,440	18.00
19.00	Deductibles		37,136	19.00
20.00	Subtotal (line 18 minus line 19)		272,304	20.00
21.00	Coinurance		2,387	21.00
22.00	Subtotal (line 20 minus line 21)		269,917	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		51,039	23.00
24.00	Adjusted reimbursable bad debts (see instructions)		33,175	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)		303,092	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)		303,092	31.00
31.01	Sequestration adjustment (see instructions)		6,062	31.01
31.02	Demonstration payment adjustment amount after sequestration		0	31.02
32.00	Interim payments		264,512	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)		32,518	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: 14-0179

Period:
From 07/01/2019
To 01/31/2020Worksheet E-3
Part VII
Date/Time Prepared:
7/28/2020 8:27 am

		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		2,741,230		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)		2,741,230	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)		2,741,230	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)		2,741,230	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		0	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		0	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		2,741,230	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	0	31.00
32.00	Deductibles		0	0	32.00
33.00	Coinurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40.00
41.00	Interim payments		0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, chapter 1, §115.2		0	0	43.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0179		Period: From 07/01/2019 To 01/31/2020		Worksheet E-4 Date/Time Prepared: 7/28/2020 8:27 am	
		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.					3.09	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)					0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA					0.25	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)					0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))					0.16	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)					3.00	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)					1.81	6.00
7.00	Enter the lesser of line 5 or line 6					1.81	7.00
		Primary Care		Other		Total	
		1.00		2.00		3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	0.00		1.06		1.06 8.00	
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	0.00		1.06		1.06 9.00	
10.00	Weighted dental and podiatric resident FTE count for the current year			0.00		10.00	
10.01	Unweighted dental and podiatric resident FTE count for the current year			0.00		10.01	
11.00	Total weighted FTE count	0.00		1.06		11.00	
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	1.98		0.92		12.00	
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	1.30		0.87		13.00	
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	1.09		0.95		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	1.09		0.95		17.00	
18.00	Per resident amount	150,800.23		149,172.29		18.00	
19.00	Approved amount for resident costs	164,372		141,714		306,086 19.00	
						1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)					0.00 20.00	
21.00	Direct GME FTE unweighted resident count over cap (see instructions)					0.00 21.00	
22.00	Allowable additional direct GME FTE Resident Count (see instructions)					0.00 22.00	
23.00	Enter the locality adjustment national average per resident amount (see instructions)					0.00 23.00	
24.00	Multiply line 22 time line 23					0 24.00	
25.00	Total direct GME amount (sum of lines 19 and 24)					306,086 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)	11,424		5,644		0 26.00	
27.00	Total Inpatient Days (see instructions)	32,704		32,704		32,704 27.00	
28.00	Ratio of inpatient days to total inpatient days	0.349315		0.172578		0.000000 28.00	
29.00	Program direct GME amount	106,920		52,824		0 159,744 29.00	
29.01	Percent reduction for MA DGME			7.00		7.00 29.01	
30.00	Reduction for direct GME payments for Medicare Advantage			3,698		0 3,698 30.00	
31.00	Net Program direct GME amount					156,046 31.00	

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0179	Period: From 07/01/2019 To 01/31/2020	Worksheet E-4 Date/Time Prepared: 7/28/2020 8:27 am
		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)		3,616,579	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)		25,163,902	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)		25,163,902	41.00
Part B Reasonable Cost				
42.00	Reasonable cost (see instructions)		13,715,049	42.00
43.00	Primary payer payments (see instructions)		0	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)		13,715,049	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)		38,878,951	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)		0.647237	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)		0.352763	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48.00	Total program GME payment (line 31)		156,046	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)		100,999	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)		55,047	50.00

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

Provider CCN: 14-0179

Period:
From 07/01/2019
To 01/31/2020

Worksheet G

Date/Time Prepared:

7/28/2020 8:27 am

	General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	1.00	2.00	3.00	4.00	
CURRENT ASSETS					
1.00 Cash on hand in banks	39,539,000	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	27,680,000	0	0	0	4.00
5.00 Other receivable	4,065,000	0	0	0	5.00
6.00 Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00 Inventory	2,104,000	0	0	0	7.00
8.00 Prepaid expenses	2,381,000	0	0	0	8.00
9.00 Other current assets	4,598,000	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)	80,367,000	0	0	0	11.00
FIXED ASSETS					
12.00 Land	9,018,000	0	0	0	12.00
13.00 Land improvements	11,109,000	0	0	0	13.00
14.00 Accumulated depreciation	-7,766,000	0	0	0	14.00
15.00 Buildings	300,875,000	0	0	0	15.00
16.00 Accumulated depreciation	-106,228,000	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	113,094,000	0	0	0	23.00
24.00 Accumulated depreciation	-85,558,000	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)	234,544,000	0	0	0	30.00
OTHER ASSETS					
31.00 Investments	592,416,000	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	95,698,000	3,225,000	0	0	34.00
35.00 Total other assets (sum of lines 31-34)	688,114,000	3,225,000	0	0	35.00
36.00 Total assets (sum of lines 11, 30, and 35)	1,003,025,000	3,225,000	0	0	36.00
CURRENT LIABILITIES					
37.00 Accounts payable	7,394,000	0	0	0	37.00
38.00 Salaries, wages, and fees payable	19,787,000	0	0	0	38.00
39.00 Payroll taxes payable	0	0	0	0	39.00
40.00 Notes and loans payable (short term)	5,606,000	0	0	0	40.00
41.00 Deferred income	0	0	0	0	41.00
42.00 Accelerated payments	0	0	0	0	42.00
43.00 Due to other funds	0	0	0	0	43.00
44.00 Other current liabilities	12,337,000	0	0	0	44.00
45.00 Total current liabilities (sum of lines 37 thru 44)	45,124,000	0	0	0	45.00
LONG TERM LIABILITIES					
46.00 Mortgage payable	180,298,000	0	0	0	46.00
47.00 Notes payable	0	0	0	0	47.00
48.00 Unsecured loans	0	0	0	0	48.00
49.00 Other long term liabilities	69,530,000	0	0	0	49.00
50.00 Total long term liabilities (sum of lines 46 thru 49)	249,828,000	0	0	0	50.00
51.00 Total liabilities (sum of lines 45 and 50)	294,952,000	0	0	0	51.00
CAPITAL ACCOUNTS					
52.00 General fund balance	708,073,000				52.00
53.00 Specific purpose fund		3,225,000			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)	708,073,000	3,225,000	0	0	59.00
60.00 Total liabilities and fund balances (sum of lines 51 and 59)	1,003,025,000	3,225,000	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0179

Period:
From 07/01/2019
To 01/31/2020

Worksheet G-1

Date/Time Prepared:
7/28/2020 8:27 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		707,518,000		4,127,000		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		9,664,007				2.00
3.00	Total (sum of line 1 and line 2)		717,182,007		4,127,000		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00	OTHER	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)		717,182,007		4,127,000		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00	RESTR ASSETS REL FOR OPER	9,109,007		902,000		0	14.00
15.00	NET ASSET TRANSFER	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)		9,109,007		902,000		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		708,073,000		3,225,000		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	OTHER		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	RESTR ASSETS REL FOR OPER		0				14.00
15.00	NET ASSET TRANSFER		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: 14-0179

Period:
From 07/01/2019
To 01/31/2020Worksheet G-2
Parts I & II
Date/Time Prepared:
7/28/2020 8:27 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	67,437,717		67,437,717	1.00
2.00	SUBPROVIDER - IPF	2,904,668		2,904,668	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)	70,342,385		70,342,385	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	10,289,342		10,289,342	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
14.10	NICU	3,262,914		3,262,914	14.10
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	13,552,256		13,552,256	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	83,894,641		83,894,641	17.00
18.00	Ancillary services	224,995,689	332,356,182	557,351,871	18.00
19.00	Outpatient services	0	0	0	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		1,549,106	1,549,106	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
24.20	OUTPATIENT PHYSICAL THERAPY	0	0	0	24.20
24.30	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	24.30
24.40	OUTPATIENT SPEECH PATHOLOGY	0	0	0	24.40
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE	0	0	0	26.00
27.00	HOSPICE	0	749,416	749,416	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	308,890,330	334,654,704	643,545,034	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		154,851,382		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00	TRANSFORMATION COSTS	668,764			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)		668,764		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		155,520,146		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0179

Period:
From 07/01/2019
To 01/31/2020

Worksheet G-3

Date/Time Prepared:
7/28/2020 8:27 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	643,545,034	1.00
2.00	Less contractual allowances and discounts on patients' accounts	539,901,080	2.00
3.00	Net patient revenues (line 1 minus line 2)	103,643,954	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	155,520,146	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-51,876,192	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	1,077,730	6.00
7.00	Income from investments	32,468,674	7.00
8.00	Revenues from telephone and other miscellaneous communication services	123,516	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	403,816	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	124,502	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	7,000	20.00
21.00	Rental of vending machines	10,966	21.00
22.00	Rental of hospital space	198,563	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER (SPECIFY)	0	24.00
24.02	OTHER NOIN OPER REVEUE	663,032	24.02
24.03	AFFILIATE SERVICES	408,442	24.03
24.04	HEALTH PROMOTION	0	24.04
24.05	OTHER CAPITAL GAINS OIN INVESMTENTS	7,602,619	24.05
24.06	MEDICAID TAX/ASSESSMENT REVENUE	8,824,204	24.06
24.07	MISCELLANEOUS REVENUE	488,010	24.07
24.08	NON RECURRING ADJUSTMENTS	788,982	24.08
24.09	SELF INSURANCE FUND INCOME	3,197,405	24.09
24.10	SCRAP SILVER REVENUE	0	24.10
24.11	MEDICAL STAFFAPPLICATIONS	48,000	24.11
24.12	VOTIVE LIGHT REVENUE	4,149	24.12
24.13	JOINT VENTURE LOSS	-396,256	24.13
24.14	UN RELAIIZED GAIN ON INVESTMENTS	5,496,845	24.14
24.17	VOLUNTEER IMPUTED SALARIES	0	24.17
25.00	Total other income (sum of lines 6-24)	61,540,199	25.00
26.00	Total (line 5 plus line 25)	9,664,007	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)	9,664,007	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 14-0179

Period:

Worksheet H

HHA CCN: 14-7404

From 07/01/2019

Date/Time Prepared:

To 01/31/2020

7/28/2020 8:27 am

Home Health
Agency I

PPS

	Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
GENERAL SERVICE COST CENTERS							
1.00 Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00 Capital Related - Movable Equipment			0		0	0	2.00
3.00 Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00 Transportation	0	0	0	0	0	0	4.00
5.00 Administrative and General	285,614	87,766	0	0	86,197	459,577	5.00
HHA REIMBURSABLE SERVICES							
6.00 Skilled Nursing Care	375,256	115,313	10,603	0	0	501,172	6.00
7.00 Physical Therapy	175,892	54,050	7,747	130,603	0	368,292	7.00
8.00 Occupational Therapy	55,666	17,105	2,742	0	0	75,513	8.00
9.00 Speech Pathology	0	0	0	910	0	910	9.00
10.00 Medical Social Services	11,945	3,670	168	0	0	15,783	10.00
11.00 Home Health Aide	12,047	3,702	960	0	0	16,709	11.00
12.00 Supplies (see instructions)	0	0	0	0	7,100	7,100	12.00
13.00 Drugs	0	0	0	0	0	0	13.00
14.00 DME	0	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00 Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00 Respiratory Therapy	0	0	0	0	0	0	16.00
17.00 Private Duty Nursing	0	0	0	0	0	0	17.00
18.00 Clinic	0	0	0	0	0	0	18.00
19.00 Health Promotion Activities	0	0	0	0	0	0	19.00
20.00 Day Care Program	0	0	0	0	0	0	20.00
21.00 Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00 Homemaker Service	0	0	0	0	0	0	22.00
23.00 All Others (specify)	0	0	0	0	0	0	23.00
23.50 Telemedicine	0	0	0	0	0	0	23.50
24.00 Total (sum of lines 1-23)	916,420	281,606	22,220	131,513	93,297	1,445,056	24.00
	Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
	7.00	8.00	9.00	10.00			
GENERAL SERVICE COST CENTERS							
1.00 Capital Related - Bldg. & Fixtures	0	0	0	0			1.00
2.00 Capital Related - Movable Equipment	0	0	0	0			2.00
3.00 Plant Operation & Maintenance	0	0	0	0			3.00
4.00 Transportation	0	0	0	0			4.00
5.00 Administrative and General	-47,529	412,048	0	412,048			5.00
HHA REIMBURSABLE SERVICES							
6.00 Skilled Nursing Care	0	501,172	0	501,172			6.00
7.00 Physical Therapy	0	368,292	0	368,292			7.00
8.00 Occupational Therapy	0	75,513	0	75,513			8.00
9.00 Speech Pathology	0	910	0	910			9.00
10.00 Medical Social Services	0	15,783	0	15,783			10.00
11.00 Home Health Aide	0	16,709	0	16,709			11.00
12.00 Supplies (see instructions)	0	7,100	0	7,100			12.00
13.00 Drugs	0	0	0	0			13.00
14.00 DME	0	0	0	0			14.00
HHA NONREIMBURSABLE SERVICES							
15.00 Home Dialysis Aide Services	0	0	0	0			15.00
16.00 Respiratory Therapy	0	0	0	0			16.00
17.00 Private Duty Nursing	0	0	0	0			17.00
18.00 Clinic	0	0	0	0			18.00
19.00 Health Promotion Activities	0	0	0	0			19.00
20.00 Day Care Program	0	0	0	0			20.00
21.00 Home Delivered Meals Program	0	0	0	0			21.00
22.00 Homemaker Service	0	0	0	0			22.00
23.00 All Others (specify)	0	0	0	0			23.00
23.50 Telemedicine	0	0	0	0			23.50
24.00 Total (sum of lines 1-23)	-47,529	1,397,527	0	1,397,527			24.00

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

COST ALLOCATION - HHA GENERAL SERVICE COST

Provider CCN: 14-0179

Period:

Worksheet H-1

HHA CCN: 14-7404

From 07/01/2019
To 01/31/2020Part I
Date/Time Prepared:
7/28/2020 8:27 amHome Health
Agency I

PPS

		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
			Bldgs & Fixtures	Movable Equipment				
			0	1.00	2.00	3.00	4.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	412,048	0	0	0	0	412,048	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	501,172	0	0	0	0	501,172	6.00
7.00	Physical Therapy	368,292	0	0	0	0	368,292	7.00
8.00	Occupational Therapy	75,513	0	0	0	0	75,513	8.00
9.00	Speech Pathology	910	0	0	0	0	910	9.00
10.00	Medical Social Services	15,783	0	0	0	0	15,783	10.00
11.00	Home Health Aide	16,709	0	0	0	0	16,709	11.00
12.00	Supplies (see instructions)	7,100	0	0	0	0	7,100	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	1,397,527	0	0	0	0	1,397,527	24.00
		Administrative & General	Total (cols. 4A + 5)					
		5.00	6.00					
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures							1.00
2.00	Capital Related - Movable Equipment							2.00
3.00	Plant Operation & Maintenance							3.00
4.00	Transportation							4.00
5.00	Administrative and General	412,048						5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	204,214	705,386					6.00
7.00	Physical Therapy	128,352	496,644					7.00
8.00	Occupational Therapy	37,221	112,734					8.00
9.00	Speech Pathology	931	1,841					9.00
10.00	Medical Social Services	10,302	26,085					10.00
11.00	Home Health Aide	4,254	20,963					11.00
12.00	Supplies (see instructions)	26,774	33,874					12.00
13.00	Drugs	0	0					13.00
14.00	DME	0	0					14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0					15.00
16.00	Respiratory Therapy	0	0					16.00
17.00	Private Duty Nursing	0	0					17.00
18.00	Clinic	0	0					18.00
19.00	Health Promotion Activities	0	0					19.00
20.00	Day Care Program	0	0					20.00
21.00	Home Delivered Meals Program	0	0					21.00
22.00	Homemaker Service	0	0					22.00
23.00	All Others (specify)	0	0					23.00
23.50	Telemedicine	0	0					23.50
24.00	Total (sum of lines 1-23)		1,397,527					24.00

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 14-0179

Period:

Worksheet H-1

HHA CCN: 14-7404

From 07/01/2019
To 01/31/2020Part II
Date/Time Prepared:
7/28/2020 8:27 amHome Health
Agency I

PPS

	Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
	Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)					
	1.00	2.00	3.00	4.00	5A.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0			0		1.00
2.00	Capital Related - Movable Equipment		0		0		2.00
3.00	Plant Operation & Maintenance	0	0	0	0		3.00
4.00	Transportation (see instructions)	0	0	0	0		4.00
5.00	Administrative and General	0	0	0	0	-412,048	5.00
	1,618,507						
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	300,971	6.00
7.00	Physical Therapy	0	0	0	0	135,868	7.00
8.00	Occupational Therapy	0	0	0	0	70,688	8.00
9.00	Speech Pathology	0	0	0	0	2,748	9.00
10.00	Medical Social Services	0	0	0	0	24,684	10.00
11.00	Home Health Aide	0	0	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	98,069	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	0	0	0	0	220,980	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0	412,048	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000	0.254585	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0179

Period:

Worksheet H-2

HHA CCN: 14-7404

From 07/01/2019
To 01/31/2020Part I
Date/Time Prepared:
7/28/2020 8:27 amHome Health
Agency I

PPS

Cost Center Description		HHA Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
			BLDG & FIXT	MVBLE EQUIP				
		0	1.00	2.00	4.00	4A	5.00	
1.00	Administrative and General	0	0	17,295	6,876	24,171	8,243	1.00
2.00	Skilled Nursing Care	705,386	0	0	6,017	711,403	180,895	2.00
3.00	Physical Therapy	496,644	0	0	3,148	499,792	113,330	3.00
4.00	Occupational Therapy	112,734	0	0	951	113,685	32,886	4.00
5.00	Speech Pathology	1,841	0	0	0	1,841	819	5.00
6.00	Medical Social Services	26,085	0	0	318	26,403	9,175	6.00
7.00	Home Health Aide	20,963	0	0	664	21,627	3,834	7.00
8.00	Supplies (see instructions)	33,874	0	0	0	33,874	23,534	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	1,397,527	0	17,295	17,974	1,432,796	372,716	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000		21.00
Cost Center Description		MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	
		6.00	7.00	8.00	9.00	10.00	11.00	
1.00	Administrative and General	0	0	0	0	0	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	0	0	0	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0179

Period:

Worksheet H-2

HHA CCN: 14-7404

From 07/01/2019

Part I

To 01/31/2020

Date/Time Prepared:

7/28/2020 8:27 am

Home Health
Agency I

PPS

Cost Center Description		MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		12.00	13.00	14.00	15.00	16.00	17.00	
1.00	Administrative and General	0	23,683	0	11	0	0	1.00
2.00	Skilled Nursing Care	0	20,724	0	0	4,367	0	2.00
3.00	Physical Therapy	0	10,844	0	0	5,248	0	3.00
4.00	Occupational Therapy	0	3,277	0	0	1,187	0	4.00
5.00	Speech Pathology	0	0	0	0	23	0	5.00
6.00	Medical Social Services	0	1,096	0	0	91	0	6.00
7.00	Home Health Aide	0	2,286	0	0	268	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	529	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	61,910	0	11	11,713	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00
Cost Center Description		NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	INTERNS & RESIDENTS		PARAMED ED PRGM	Subtotal	
		19.00	20.00	SERVICES-SALAR Y & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV	23.00	24.00	
1.00	Administrative and General	0	0	0	0	0	56,108	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	917,389	2.00
3.00	Physical Therapy	0	0	0	0	0	629,214	3.00
4.00	Occupational Therapy	0	0	0	0	0	151,035	4.00
5.00	Speech Pathology	0	0	0	0	0	2,683	5.00
6.00	Medical Social Services	0	0	0	0	0	36,765	6.00
7.00	Home Health Aide	0	0	0	0	0	28,015	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	57,937	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	0	0	0	0	1,879,146	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0179

Period:

Worksheet H-2

HHA CCN: 14-7404

From 07/01/2019
To 01/31/2020Part I
Date/Time Prepared:
7/28/2020 8:27 amHome Health
Agency I

PPS

Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs		
		25.00	26.00	27.00	28.00		
1.00	Administrative and General	0	56,108				1.00
2.00	Skilled Nursing Care	0	917,389	28,235	945,624		2.00
3.00	Physical Therapy	0	629,214	19,365	648,579		3.00
4.00	Occupational Therapy	0	151,035	4,648	155,683		4.00
5.00	Speech Pathology	0	2,683	83	2,766		5.00
6.00	Medical Social Services	0	36,765	1,132	37,897		6.00
7.00	Home Health Aide	0	28,015	862	28,877		7.00
8.00	Supplies (see instructions)	0	57,937	1,783	59,720		8.00
9.00	Drugs	0	0	0	0		9.00
10.00	DME	0	0	0	0		10.00
11.00	Home Dialysis Aide Services	0	0	0	0		11.00
12.00	Respiratory Therapy	0	0	0	0		12.00
13.00	Private Duty Nursing	0	0	0	0		13.00
14.00	Clinic	0	0	0	0		14.00
15.00	Health Promotion Activities	0	0	0	0		15.00
16.00	Day Care Program	0	0	0	0		16.00
17.00	Home Delivered Meals Program	0	0	0	0		17.00
18.00	Homemaker Service	0	0	0	0		18.00
19.00	All Others (specify)	0	0	0	0		19.00
19.50	Telemedicine	0	0	0	0		19.50
20.00	Total (sum of lines 1-19) (2)	0	1,879,146	56,108	1,879,146		20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.			0.030777			21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-0179

Period:

Worksheet H-2

HHA CCN: 14-7404

From 07/01/2019
To 01/31/2020Part II
Date/Time Prepared:
7/28/2020 8:27 amHome Health
Agency I

PPS

Cost Center Description		CAPITAL RELATED COSTS			Reconciliation	Agency 1			
		BLDG & FIXT ((SQUARE FEET))	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (FTE'S SALARIES))		ADMINISTRATIVE & GENERAL (ACCUM COST)			MAINTENANCE & REPAIRS ((SQUARE FEET))
						1.00			2.00
1.00	Administrative and General	0	17,351	7,242	29,829	54,000	0	1.00	
2.00	Skilled Nursing Care	0	0	6,337	473,711	1,185,114	0	2.00	
3.00	Physical Therapy	0	0	3,316	242,676	742,468	0	3.00	
4.00	Occupational Therapy	0	0	1,002	101,766	215,451	0	4.00	
5.00	Speech Pathology	0	0	0	3,522	5,363	0	5.00	
6.00	Medical Social Services	0	0	335	33,709	60,112	0	6.00	
7.00	Home Health Aide	0	0	699	3,492	25,119	0	7.00	
8.00	Supplies (see instructions)	0	0	0	120,306	154,180	0	8.00	
9.00	Drugs	0	0	0	0	0	0	9.00	
10.00	DME	0	0	0	0	0	0	10.00	
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00	
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00	
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00	
14.00	Clinic	0	0	0	0	0	0	14.00	
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00	
16.00	Day Care Program	0	0	0	0	0	0	16.00	
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00	
18.00	Homemaker Service	0	0	0	0	0	0	18.00	
19.00	All Others (specify)	0	0	0	0	0	0	19.00	
19.50	Telemedicine	0	0	0	0	0	0	19.50	
20.00	Total (sum of lines 1-19)	0	17,351	18,931		2,441,807	0	20.00	
21.00	Total cost to be allocated	0	17,295	17,974		372,716	0	21.00	
22.00	Unit cost multiplier	0.000000	0.996773	0.949448		0.152639	0.000000	22.00	
Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE ((POUNDS OF LAUNDRY))	HOUSEKEEPING (SQUARE FEET)	DIETARY ((MEALS SERVED))	CAFETERIA ((MEALS SERVED))	MAINTENANCE OF PERSONNEL ((NUMBER HOUSED))		
		7.00	8.00	9.00	10.00	11.00	12.00		
1.00	Administrative and General	0	0	0	0	0	0	1.00	
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00	
3.00	Physical Therapy	0	0	0	0	0	0	3.00	
4.00	Occupational Therapy	0	0	0	0	0	0	4.00	
5.00	Speech Pathology	0	0	0	0	0	0	5.00	
6.00	Medical Social Services	0	0	0	0	0	0	6.00	
7.00	Home Health Aide	0	0	0	0	0	0	7.00	
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00	
9.00	Drugs	0	0	0	0	0	0	9.00	
10.00	DME	0	0	0	0	0	0	10.00	
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00	
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00	
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00	
14.00	Clinic	0	0	0	0	0	0	14.00	
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00	
16.00	Day Care Program	0	0	0	0	0	0	16.00	
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00	
18.00	Homemaker Service	0	0	0	0	0	0	18.00	
19.00	All Others (specify)	0	0	0	0	0	0	19.00	
19.50	Telemedicine	0	0	0	0	0	0	19.50	
20.00	Total (sum of lines 1-19)	0	0	0	0	0	0	20.00	
21.00	Total cost to be allocated	0	0	0	0	0	0	21.00	
22.00	Unit cost multiplier	0.000000	0.000000	0.000000	0.000000	0.000000	0.000000	22.00	

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-0179

Period:

Worksheet H-2

HHA CCN: 14-7404

From 07/01/2019
To 01/31/2020Part II
Date/Time Prepared:
7/28/2020 8:27 amHome Health
Agency I

PPS

Cost Center Description		NURSING ADMINISTRATION ((DIRECT NRS HRS))	CENTRAL SERVICES & SUPPLY ((COSTED REQUIS))	PHARMACY ((COSTED REQUIS))	MEDICAL RECORDS & LIBRARY (GROSS REVENUE)	SOCIAL SERVICE ((TIME SPENT))	NONPHYSICIAN ANESTHETISTS ((ASSIGNED TIME))	
		13.00	14.00	15.00	16.00	17.00	19.00	
1.00	Administrative and General	7,242	0	29	0	0	0	1.00
2.00	Skilled Nursing Care	6,337	0	0	577,568	0	0	2.00
3.00	Physical Therapy	3,316	0	0	694,007	0	0	3.00
4.00	Occupational Therapy	1,002	0	0	156,972	0	0	4.00
5.00	Speech Pathology	0	0	0	3,091	0	0	5.00
6.00	Medical Social Services	335	0	0	12,099	0	0	6.00
7.00	Home Health Aide	699	0	0	35,456	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	69,913	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	18,931	0	29	1,549,106	0	0	20.00
21.00	Total cost to be allocated	61,910	0	11	11,713	0	0	21.00
22.00	Unit cost multiplier	3.270297	0.000000	0.379310	0.007561	0.000000	0.000000	22.00
Cost Center Description		NURSING SCHOOL ((ASSIGNED TIME))	INTERNS & RESIDENTS SERVICES-SALAR Y & FRINGES APPRV ((ASSIGNED TIME))		SERVICES-OTHER PRGM COSTS APPRV ((ASSIGNED TIME))	PARAMED ED PRGM ((ASSIGNED TIME))		
		20.00	21.00	22.00	23.00			
1.00	Administrative and General	0	0	0	0			1.00
2.00	Skilled Nursing Care	0	0	0	0			2.00
3.00	Physical Therapy	0	0	0	0			3.00
4.00	Occupational Therapy	0	0	0	0			4.00
5.00	Speech Pathology	0	0	0	0			5.00
6.00	Medical Social Services	0	0	0	0			6.00
7.00	Home Health Aide	0	0	0	0			7.00
8.00	Supplies (see instructions)	0	0	0	0			8.00
9.00	Drugs	0	0	0	0			9.00
10.00	DME	0	0	0	0			10.00
11.00	Home Dialysis Aide Services	0	0	0	0			11.00
12.00	Respiratory Therapy	0	0	0	0			12.00
13.00	Private Duty Nursing	0	0	0	0			13.00
14.00	Clinic	0	0	0	0			14.00
15.00	Health Promotion Activities	0	0	0	0			15.00
16.00	Day Care Program	0	0	0	0			16.00
17.00	Home Delivered Meals Program	0	0	0	0			17.00
18.00	Homemaker Service	0	0	0	0			18.00
19.00	All Others (specify)	0	0	0	0			19.00
19.50	Telemedicine	0	0	0	0			19.50
20.00	Total (sum of lines 1-19)	0	0	0	0			20.00
21.00	Total cost to be allocated	0	0	0	0			21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.000000	0.000000			22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0179

Period:

Worksheet H-3

HHA CCN: 14-7404

From 07/01/2019
To 01/31/2020Part I
Date/Time Prepared:
7/28/2020 8:27 am

				Title XVIII		Home Health Agency I	PPS
Cost Center Description		From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)
		0	1.00	2.00	3.00	4.00	5.00
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	945,624		945,624	3,534	267.58
2.00	Physical Therapy	3.00	648,579	0	648,579	4,032	160.86
3.00	Occupational Therapy	4.00	155,683	0	155,683	914	170.33
4.00	Speech Pathology	5.00	2,766	0	2,766	18	153.67
5.00	Medical Social Services	6.00	37,897		37,897	56	676.73
6.00	Home Health Aide	7.00	28,877		28,877	320	90.24
7.00	Total (sum of lines 1-6)		1,819,426	0	1,819,426	8,874	
				Program Visits			
				Part B			
				Not Subject to Deductibles & Coinsurance		Subject to Deductibles	
		0	1.00	2.00	3.00	4.00	5.00
Limitation Cost Computation							
8.00	Skilled Nursing Care		16974	0	2,109		8.00
9.00	Physical Therapy		16974	0	2,063		9.00
10.00	Occupational Therapy		16974	0	741		10.00
11.00	Speech Pathology		16974	0	10		11.00
12.00	Medical Social Services		16974	0	32		12.00
13.00	Home Health Aide		16974	0	213		13.00
14.00	Total (sum of lines 8-13)			0	5,168		14.00
		From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)
		0	1.00	2.00	3.00	4.00	5.00
Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	59,720	0	59,720	493,803	0.120939
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000
				Program Visits		Cost of Services	
				Part B		Part B	
				Not Subject to Deductibles & Coinsurance		Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	2,109		0	564,326	1.00
2.00	Physical Therapy	0	2,063		0	331,854	2.00
3.00	Occupational Therapy	0	741		0	126,215	3.00
4.00	Speech Pathology	0	10		0	1,537	4.00
5.00	Medical Social Services	0	32		0	21,655	5.00
6.00	Home Health Aide	0	213		0	19,221	6.00
7.00	Total (sum of lines 1-6)	0	5,168		0	1,064,808	7.00
		6.00	7.00	8.00	9.00	10.00	11.00
Limitation Cost Computation							
8.00	Skilled Nursing Care						8.00
9.00	Physical Therapy						9.00
10.00	Occupational Therapy						10.00
11.00	Speech Pathology						11.00
12.00	Medical Social Services						12.00
13.00	Home Health Aide						13.00
14.00	Total (sum of lines 8-13)						14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0179

Period:

Worksheet H-3

HHA CCN: 14-7404

From 07/01/2019
To 01/31/2020Part I
Date/Time Prepared:
7/28/2020 8:27 am

Title XVIII

Home Health
Agency I

PPS

Cost Center Description		Program Covered Charges			Cost of Services	Agency 1			
		Part A	Part B		Part A	Part B			
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		
			6.00	7.00		8.00	9.00		10.00
	Supplies and Drugs Cost Computations								
15.00	Cost of Medical Supplies	0	0	164,013	0	0	19,836	15.00	
16.00	Cost of Drugs		0	0		0	0	16.00	
Cost Center Description		Total Program Cost (sum of cols. 9-10)							
		12.00							
		PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
Cost Per Visit Computation									
1.00	Skilled Nursing Care	564,326							1.00
2.00	Physical Therapy	331,854							2.00
3.00	Occupational Therapy	126,215							3.00
4.00	Speech Pathology	1,537							4.00
5.00	Medical Social Services	21,655							5.00
6.00	Home Health Aide	19,221							6.00
7.00	Total (sum of lines 1-6)	1,064,808							7.00
Cost Center Description									
		12.00							
Limitation Cost Computation									
8.00	Skilled Nursing Care								8.00
9.00	Physical Therapy								9.00
10.00	Occupational Therapy								10.00
11.00	Speech Pathology								11.00
12.00	Medical Social Services								12.00
13.00	Home Health Aide								13.00
14.00	Total (sum of lines 8-13)								14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0179

Period:

Worksheet H-3

HHA CCN: 14-7404

From 07/01/2019
To 01/31/2020Part II
Date/Time Prepared:
7/28/2020 8:27 am

Title XVIII

Home Health
Agency I

PPS

Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
	0	1.00	2.00	3.00	4.00		
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00 Physical Therapy	66.00	0.313789	0	0	col. 2, line 2.00		1.00
2.00 Occupational Therapy							2.00
3.00 Speech Pathology	68.00	0.212231	0	0	col. 2, line 4.00		3.00
4.00 Cost of Medical Supplies	71.00	0.436735	0	0	col. 2, line 15.00		4.00
5.00 Cost of Drugs	73.00	0.187162	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

		Provider CCN: 14-0179	Period: From 07/01/2019	Worksheet H-4
		HHA CCN: 14-7404	To 01/31/2020	Part I-II
				Date/Time Prepared: 7/28/2020 8:27 am
		Title XVIII	Home Health Agency I	PPS
		Part A	Part B	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		1.00	2.00	3.00
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0
2.00	Total charges	0	0	0
Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(b)	0	0	0
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000
6.00	Total customary charges (see instructions)	0	0	0
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0
9.00	Primary payer amounts	0	0	0
			Part A Services	Part B Services
			1.00	2.00
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT				
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	0	870,814	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	77,258	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	22,347	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	0	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	0	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	0	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)	0	0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	0	970,419	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	970,419	24.00
25.00	Coinsurance billed to program patients (from your records)	0	0	25.00
26.00	Net cost (line 24 minus line 25)	0	970,419	26.00
27.00	Reimbursable bad debts (from your records)	0	0	27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	0	28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)	0	970,419	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	30.50
30.99	Demonstration payment adjustment amount before sequestration	0	0	30.99
31.00	Subtotal (see instructions)	0	970,419	31.00
31.01	Sequestration adjustment (see instructions)	0	19,409	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	0	31.02
32.00	Interim payments (see instructions)	0	951,010	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)	0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	35.00

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

Provider CCN: 14-0179

Period:

Worksheet H-5

HHA CCN: 14-7404

From 07/01/2019

Date/Time Prepared:

To 01/31/2020

7/28/2020 8:27 am

Home Health
Agency I

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		951,010	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		951,010	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		951,010	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 14-0179

Period:

Worksheet 0

Hospice CCN: 14-1511

From 07/01/2019
To 01/31/2020

Date/Time Prepared:

7/28/2020 8:27 am

		Hospice I				
		SALARIES	OTHER	SUBTOTAL (col. 1 plus col. 2)	RECLASSIFI- CATIONS	SUBTOTAL
		1.00	2.00	3.00	4.00	5.00
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT*		0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*		0	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0	0	0	3.00
4.00	ADMINISTRATIVE & GENERAL*	184,772	129,716	314,488	-12,721	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0	0	0	6.00
7.00	HOUSEKEEPING*	0	0	0	0	7.00
8.00	DIETARY*	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION*	0	0	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0	0	0	10.00
11.00	MEDICAL RECORDS*	0	0	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	0	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	17,206	5,712	22,918	0	13.00
14.00	PHARMACY*	0	5,804	5,804	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE*	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES					17.00
DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED**		60,844	60,844	0	25.00
26.00	PHYSICIAN SERVICES**	0	39,231	39,231	0	26.00
27.00	NURSE PRACTITIONER**	0	0	0	0	27.00
28.00	REGISTERED NURSE**	221,983	79,908	301,891	0	28.00
29.00	LPN/LVN**	0	0	0	0	29.00
30.00	PHYSICAL THERAPY**	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY**	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES**	27,122	9,205	36,327	0	33.00
34.00	SPIRITUAL COUNSELING**	29,720	11,085	40,805	0	34.00
35.00	DIETARY COUNSELING**	0	0	0	0	35.00
36.00	COUNSELING - OTHER**	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES**	30,251	12,950	43,201	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION**	0	0	0	0	39.00
40.00	IMAGING SERVICES**	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS**	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	9,547	9,547	0	42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES**	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0	0	0	46.00
NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM *	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM *	0	0	0	0	61.00
62.00	FUNDRAISING*	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0	0	0	65.00
66.00	RESIDENTIAL CARE*	0	0	0	0	66.00
67.00	ADVERTISING*	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0	0	0	68.00
69.00	THRIFT STORE*	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	0	0	71.00
100.00	TOTAL	511,054	364,002	875,056	-12,721	100.00

* Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.

** See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS

Provider CCN: 14-0179

Period:

Worksheet 0

Hospice CCN: 14-1511

From 07/01/2019
To 01/31/2020Date/Time Prepared:
7/28/2020 8:27 am

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	Hospice I
		6.00	7.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT*	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP*	0	0	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	0	3.00
4.00	ADMINISTRATIVE & GENERAL*	0	301,767	4.00
5.00	PLANT OPERATION & MAINTENANCE*	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE*	0	0	6.00
7.00	HOUSEKEEPING*	0	0	7.00
8.00	DIETARY*	0	0	8.00
9.00	NURSING ADMINISTRATION*	0	0	9.00
10.00	ROUTINE MEDICAL SUPPLIES*	0	0	10.00
11.00	MEDICAL RECORDS*	0	0	11.00
12.00	STAFF TRANSPORTATION*	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION*	0	22,918	13.00
14.00	PHARMACY*	0	5,804	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES*	0	0	15.00
16.00	OTHER GENERAL SERVICE*	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			17.00
DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED**	0	60,844	25.00
26.00	PHYSICIAN SERVICES**	0	39,231	26.00
27.00	NURSE PRACTITIONER**	0	0	27.00
28.00	REGISTERED NURSE**	0	301,891	28.00
29.00	LPN/LVN**	0	0	29.00
30.00	PHYSICAL THERAPY**	0	0	30.00
31.00	OCCUPATIONAL THERAPY**	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY**	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES**	0	36,327	33.00
34.00	SPIRITUAL COUNSELING**	0	40,805	34.00
35.00	DIETARY COUNSELING**	0	0	35.00
36.00	COUNSELING - OTHER**	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES**	0	43,201	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	0	0	38.00
39.00	PATIENT TRANSPORTATION**	0	0	39.00
40.00	IMAGING SERVICES**	0	0	40.00
41.00	LABS & DIAGNOSTICS**	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE**	0	9,547	42.00
42.50	DRUGS CHARGED TO PATIENTS**	0	0	42.50
43.00	OUTPATIENT SERVICES**	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY**	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY**	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	0	0	46.00
NONREIMBURSABLE COST CENTERS				
60.00	BEREAVEMENT PROGRAM *	0	0	60.00
61.00	VOLUNTEER PROGRAM *	0	0	61.00
62.00	FUNDRAISING*	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM*	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES*	0	0	65.00
66.00	RESIDENTIAL CARE*	0	0	66.00
67.00	ADVERTISING*	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING*	0	0	68.00
69.00	THRIFT STORE*	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD*	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	71.00
100.00	TOTAL	0	862,335	100.00

* Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.

** See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE CONTINUOUS HOME CARE

Provider CCN: 14-0179

Period:

Worksheet 0-1

Hospice CCN: 14-1511

From 07/01/2019
To 01/31/2020

Date/Time Prepared:

7/28/2020 8:27 am

					Hospice I			
		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI- CATIONS	SUBTOTAL		
		1.00	2.00	3.00	4.00	5.00		
	DIRECT PATIENT CARE SERVICE COST CENTERS							
25.00	INPATIENT CARE-CONTRACTED						25.00	
26.00	PHYSICIAN SERVICES	0	39,231	39,231	0	39,231	26.00	
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00	
28.00	REGISTERED NURSE	221,983	79,908	301,891	0	301,891	28.00	
29.00	LPN/LVN	0	0	0	0	0	29.00	
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00	
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00	
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00	
33.00	MEDICAL SOCIAL SERVICES	27,122	9,205	36,327	0	36,327	33.00	
34.00	SPIRITUAL COUNSELING	29,720	11,085	40,805	0	40,805	34.00	
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00	
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00	
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	30,251	12,950	43,201	0	43,201	37.00	
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00	
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00	
40.00	IMAGING SERVICES	0	0	0	0	0	40.00	
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00	
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	9,547	9,547	0	9,547	42.00	
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50	
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00	
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00	
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00	
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00	
100.00	TOTAL *	309,076	161,926	471,002	0	471,002	100.00	

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 50.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6.00	7.00	
DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED			25.00
26.00	PHYSICIAN SERVICES	0	39,231	26.00
27.00	NURSE PRACTITIONER	0	0	27.00
28.00	REGISTERED NURSE	0	301,891	28.00
29.00	LPN/LVN	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	36,327	33.00
34.00	SPIRITUAL COUNSELING	0	40,805	34.00
35.00	DIETARY COUNSELING	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	43,201	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	39.00
40.00	IMAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	9,547	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00	TOTAL *	0	471,002	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 50.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE INPATIENT
RESPIRE CARE

Provider CCN: 14-0179

Period:

Worksheet 0-3

Hospice CCN: 14-1511

From 07/01/2019
To 01/31/2020Date/Time Prepared:
7/28/2020 8:27 am

				Hospice I			
		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	RECLASSIFI- CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED		0	0	0	0	25.00
26.00	PHYSICIAN SERVICES	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	0	0	0	0	0	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	0	0	0	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	0	0	0	0	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	0	0	0	0	0	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 52.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6.00	7.00	
DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED	0	0	25.00
26.00	PHYSICIAN SERVICES	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	27.00
28.00	REGISTERED NURSE	0	0	28.00
29.00	LPN/LVN	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	33.00
34.00	SPIRITUAL COUNSELING	0	0	34.00
35.00	DIETARY COUNSELING	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	0	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	39.00
40.00	IMAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00	TOTAL *	0	0	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 52.

ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE GENERAL
INPATIENT CARE

Provider CCN: 14-0179

Period:
From 07/01/2019
To 01/31/2020

Worksheet 0-4

Hospice CCN: 14-1511

Date/Time Prepared:
7/28/2020 8:27 am

		SALARIES	OTHER	SUBTOTAL (col. 1 + col. 2)	Hospice I RECLASSIFI- CATIONS	SUBTOTAL	
		1.00	2.00	3.00	4.00	5.00	
DIRECT PATIENT CARE SERVICE COST CENTERS							
25.00	INPATIENT CARE-CONTRACTED		60,844	60,844	0	60,844	25.00
26.00	PHYSICIAN SERVICES	0	0	0	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27.00
28.00	REGISTERED NURSE	0	0	0	0	0	28.00
29.00	LPN/LVN	0	0	0	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	0	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	0	0	0	33.00
34.00	SPIRITUAL COUNSELING	0	0	0	0	0	34.00
35.00	DIETARY COUNSELING	0	0	0	0	0	35.00
36.00	COUNSELING - OTHER	0	0	0	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	0	0	0	0	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	0	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	0	0	0	39.00
40.00	IMAGING SERVICES	0	0	0	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	0	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	0	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	0	0	46.00
100.00	TOTAL *	0	60,844	60,844	0	60,844	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

		ADJUSTMENTS	TOTAL (col. 5 ± col. 6)	
		6.00	7.00	
DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	INPATIENT CARE-CONTRACTED	0	60,844	25.00
26.00	PHYSICIAN SERVICES	0	0	26.00
27.00	NURSE PRACTITIONER	0	0	27.00
28.00	REGISTERED NURSE	0	0	28.00
29.00	LPN/LVN	0	0	29.00
30.00	PHYSICAL THERAPY	0	0	30.00
31.00	OCCUPATIONAL THERAPY	0	0	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	0	0	33.00
34.00	SPIRITUAL COUNSELING	0	0	34.00
35.00	DIETARY COUNSELING	0	0	35.00
36.00	COUNSELING - OTHER	0	0	36.00
37.00	HOSPICE AIDE & HOME MAKER SERVICES	0	0	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38.00
39.00	PATIENT TRANSPORTATION	0	0	39.00
40.00	IMAGING SERVICES	0	0	40.00
41.00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	42.00
42.50	DRUGS CHARGED TO PATIENTS	0	0	42.50
43.00	OUTPATIENT SERVICES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00	TOTAL *	0	60,844	100.00

* Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

COST ALLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET
EXPENSES FOR ALLOCATION

Provider CCN: 14-0179

Period:

Worksheet 0-5

Hospice CCN: 14-1511

From 07/01/2019
To 01/31/2020Date/Time Prepared:
7/28/2020 8:27 am

Descriptions		Hospice I		TOTAL EXPENSES (sum of cols. 1 + 2)	
		HOSPICE DIRECT EXPENSES (see instructions)	GENERAL SERVICE EXPENSES FROM WKST B PART I (see instructions)		
		1.00	2.00	3.00	
GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	15,032	15,032	2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	12,674	12,674	3.00
4.00	ADMINISTRATIVE & GENERAL	301,767	231,528	533,295	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	7.00
8.00	DIETARY	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	28,713	28,713	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	10.00
11.00	MEDICAL RECORDS	0	5,666	5,666	11.00
12.00	STAFF TRANSPORTATION	0	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	22,918	0	22,918	13.00
14.00	PHARMACY	5,804	2,248	8,052	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0	0	17.00
LEVEL OF CARE					
50.00	HOSPICE CONTINUOUS HOME CARE	471,002	0	471,002	50.00
51.00	HOSPICE ROUTINE HOME CARE	0	0	0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	60,844	0	60,844	53.00
NONREIMBURSABLE COST CENTERS					
60.00	BEREAVEMENT PROGRAM	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	66.00
67.00	ADVERTISING	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	99.00
100.00	TOTAL	862,335	295,861	1,158,196	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-0179

Period:

Worksheet 0-6

Hospice CCN: 14-1511

From 07/01/2019

Part I

To 01/31/2020

Date/Time Prepared:

7/28/2020 8:27 am

Descriptions		TOTAL EXPENSES		CAP REL BLDG & FIX	CAP REL MVBLE EQUIP	Hospice I EMPLOYEE BENEFITS DEPARTMENT	SUBTOTAL	
		0	1.00	2.00	3.00	3A		
GENERAL SERVICE COST CENTERS								
1.00	CAP REL COSTS-BLDG & FIXT	0	0					1.00
2.00	CAP REL COSTS-MVBLE EQUIP	15,032		15,032				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	12,674	0	0	12,674			3.00
4.00	ADMINISTRATIVE & GENERAL	533,295	0	15,032	11,633		559,960	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0		0	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0		0	6.00
7.00	HOUSEKEEPING	0	0	0	0		0	7.00
8.00	DIETARY	0	0	0	0		0	8.00
9.00	NURSING ADMINISTRATION	28,713	0	0	0		28,713	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0		0	10.00
11.00	MEDICAL RECORDS	5,666	0	0	0		5,666	11.00
12.00	STAFF TRANSPORTATION	0	0	0	0		0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	22,918	0	0	1,041		23,959	13.00
14.00	PHARMACY	8,052	0	0	0		8,052	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0		0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0		0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0	0	0		0	17.00
LEVEL OF CARE								
50.00	HOSPICE CONTINUOUS HOME CARE	471,002			0		471,002	50.00
51.00	HOSPICE ROUTINE HOME CARE	0			0		0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0		0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	60,844	0	0	0		60,844	53.00
NONREIMBURSABLE COST CENTERS								
60.00	BEREAVEMENT PROGRAM	0	0	0	0		0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0		0	61.00
62.00	FUNDRAISING	0	0	0	0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0		0	66.00
67.00	ADVERTISING	0	0	0	0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0		0	68.00
69.00	THRIFT STORE	0	0	0	0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0					0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0		0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0		0	99.00
100.00	TOTAL	1,158,196	0	15,032	12,674		1,158,196	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-0179

Period:

Worksheet 0-6

Hospice CCN: 14-1511

From 07/01/2019
To 01/31/2020Part I
Date/Time Prepared:
7/28/2020 8:27 am

Descriptions		ADMINISTRATIVE & GENERAL		PLANT OPERATION & MAINTENANCE	LAUNDRY & LINEN SERVICE	Hospice I HOUSEKEEPING	DIETARY	
		4.00	5.00	6.00	7.00	8.00		
GENERAL SERVICE COST CENTERS								
1.00	CAP REL COSTS-BLDG & FIXT							1.00
2.00	CAP REL COSTS-MVBLE EQUIP							2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT							3.00
4.00	ADMINISTRATIVE & GENERAL	559,960						4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0					5.00
6.00	LAUNDRY & LINEN SERVICE	0	0		0			6.00
7.00	HOUSEKEEPING	0	0			0		7.00
8.00	DIETARY	0	0			0	0	8.00
9.00	NURSING ADMINISTRATION	26,876	0			0		9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0			0		10.00
11.00	MEDICAL RECORDS	5,303	0			0		11.00
12.00	STAFF TRANSPORTATION	0	0			0		12.00
13.00	VOLUNTEER SERVICE COORDINATION	22,426	0			0		13.00
14.00	PHARMACY	7,537	0			0		14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0			0		15.00
16.00	OTHER GENERAL SERVICE	0	0			0		16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0			0		17.00
LEVEL OF CARE								
50.00	HOSPICE CONTINUOUS HOME CARE	440,867						50.00
51.00	HOSPICE ROUTINE HOME CARE	0						51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0		0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	56,951	0		0	0	0	53.00
NONREIMBURSABLE COST CENTERS								
60.00	BEREAVEMENT PROGRAM	0	0			0		60.00
61.00	VOLUNTEER PROGRAM	0	0			0		61.00
62.00	FUNDRAISING	0	0			0		62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0			0		63.00
64.00	PALLIATIVE CARE PROGRAM	0	0			0		64.00
65.00	OTHER PHYSICIAN SERVICES	0	0			0		65.00
66.00	RESIDENTIAL CARE	0	0		0	0	0	66.00
67.00	ADVERTISING	0	0			0		67.00
68.00	TELEHEALTH/TELEMONITORING	0	0			0		68.00
69.00	THRIFT STORE	0	0			0		69.00
70.00	NURSING FACILITY ROOM & BOARD							70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0		0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0		0	0	0	99.00
100.00	TOTAL	559,960	0		0	0	0	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-0179

Period:

Worksheet 0-6

Hospice CCN: 14-1511

From 07/01/2019
To 01/31/2020Part I
Date/Time Prepared:
7/28/2020 8:27 am

Descriptions		Hospice I					
		NURSING ADMINISTRATION	ROUTINE MEDICAL SUPPLIES	MEDICAL RECORDS	STAFF TRANSPORTATION	VOLUNTEER SERVICE COORDINATION	
		9.00	10.00	11.00	12.00	13.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION	55,589					9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0				10.00
11.00	MEDICAL RECORDS	0		10,969			11.00
12.00	STAFF TRANSPORTATION	0			0		12.00
13.00	VOLUNTEER SERVICE COORDINATION	3,792			0	50,177	13.00
14.00	PHARMACY	0			0	0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0			0	0	15.00
16.00	OTHER GENERAL SERVICE	0			0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES						17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	10,493	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	51,797	0	0	0	0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	1,299	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	476	0	48,878	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM	0			0	0	60.00
61.00	VOLUNTEER PROGRAM	0			0	0	61.00
62.00	FUNDRAISING	0			0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0			0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0			0	0	65.00
66.00	RESIDENTIAL CARE	0			0	0	66.00
67.00	ADVERTISING	0			0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0			0	0	68.00
69.00	THRIFT STORE	0			0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0			0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	55,589	0	10,969	0	50,177	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS

Provider CCN: 14-0179

Period:

Worksheet 0-6

Hospice CCN: 14-1511

From 07/01/2019
To 01/31/2020Part I
Date/Time Prepared:
7/28/2020 8:27 am

Descriptions		Hospice I				TOTAL	
		PHARMACY	PHYSICIAN ADMINISTRATIVE SERVICES	OTHER GENERAL SERVICE	PATIENT/ RESIDENTIAL CARE SERVICES		
		14.00	15.00	16.00	17.00	18.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5.00
6.00	LAUNDRY & LINEN SERVICE						6.00
7.00	HOUSEKEEPING						7.00
8.00	DIETARY						8.00
9.00	NURSING ADMINISTRATION						9.00
10.00	ROUTINE MEDICAL SUPPLIES						10.00
11.00	MEDICAL RECORDS						11.00
12.00	STAFF TRANSPORTATION						12.00
13.00	VOLUNTEER SERVICE COORDINATION						13.00
14.00	PHARMACY	15,589					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0				15.00
16.00	OTHER GENERAL SERVICE	0		0			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES				0		17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE	0	0	0		922,362	50.00
51.00	HOSPICE ROUTINE HOME CARE	15,589	0	0		67,386	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	1,299	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	167,149	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD					0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER	0	0	0	0	0	99.00
100.00	TOTAL	15,589	0	0	0	1,158,196	100.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 14-0179

Period:

Worksheet 0-6

Hospice CCN: 14-1511

From 07/01/2019
To 01/31/2020Part II
Date/Time Prepared:
7/28/2020 8:27 am

Cost Center Descriptions		CAP REL BLDG & FIX (SQUARE FEET)	CAP REL MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Hospice I RECONCILIATION	ADMINISTRATIVE & GENERAL (ACCUMULATED COSTS)	
		1.00	2.00	3.00	4A	4.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0					1.00
2.00	CAP REL COSTS-MVBLE EQUIP		29,664				2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	12,528			3.00
4.00	ADMINISTRATIVE & GENERAL	0	29,664	11,499	-559,960	598,236	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	0	5.00
6.00	LAUNDRY & LINEN SERVICE	0	0	0	0	0	6.00
7.00	HOUSEKEEPING	0	0	0	0	0	7.00
8.00	DIETARY	0	0	0	0	0	8.00
9.00	NURSING ADMINISTRATION	0	0	0	0	28,713	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0	0	0	0	0	10.00
11.00	MEDICAL RECORDS	0	0	0	0	5,666	11.00
12.00	STAFF TRANSPORTATION	0	0	0	0	0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0	0	1,029	0	23,959	13.00
14.00	PHARMACY	0	0	0	0	8,052	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	0	15.00
16.00	OTHER GENERAL SERVICE	0	0	0	0	0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0	0	0	0	0	17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE			0	0	471,002	50.00
51.00	HOSPICE ROUTINE HOME CARE			0	0	0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	60,844	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM	0	0	0	0	0	61.00
62.00	FUNDRAISING	0	0	0	0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0	0	0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0	0	0	0	0	64.00
65.00	OTHER PHYSICIAN SERVICES	0	0	0	0	0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0	0	0	0	0	67.00
68.00	TELEHEALTH/TELEMONITORING	0	0	0	0	0	68.00
69.00	THRIFT STORE	0	0	0	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD	0	0	0	0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	0	15,032	12,674		559,960	100.00
101.00	UNIT COST MULTIPLIER	0.000000	0.506742	1.011654		0.936019	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 14-0179

Period:

Worksheet 0-6

Hospice CCN: 14-1511

From 07/01/2019
To 01/31/2020Part II
Date/Time Prepared:
7/28/2020 8:27 am

Cost Center Descriptions		Hospice I					
		PLANT OPERATION & MAINTENANCE (SQUARE FEET)	LAUNDRY & LINEN SERVICE (IN-FACILITY DAYS)	HOUSEKEEPING (SQUARE FEET)	DIETARY (IN-FACILITY DAYS)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	
		5.00	6.00	7.00	8.00	9.00	
GENERAL SERVICE COST CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4.00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE	0					5.00
6.00	LAUNDRY & LINEN SERVICE	0	0				6.00
7.00	HOUSEKEEPING	0		0			7.00
8.00	DIETARY	0		0	0		8.00
9.00	NURSING ADMINISTRATION	0		0		15,246	9.00
10.00	ROUTINE MEDICAL SUPPLIES	0		0		0	10.00
11.00	MEDICAL RECORDS	0		0		0	11.00
12.00	STAFF TRANSPORTATION	0		0		0	12.00
13.00	VOLUNTEER SERVICE COORDINATION	0		0		1,040	13.00
14.00	PHARMACY	0		0		0	14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0		0	15.00
16.00	OTHER GENERAL SERVICE	0		0		0	16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES	0		0		0	17.00
LEVEL OF CARE							
50.00	HOSPICE CONTINUOUS HOME CARE					0	50.00
51.00	HOSPICE ROUTINE HOME CARE					14,206	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	0	0	52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0	0	0	53.00
NONREIMBURSABLE COST CENTERS							
60.00	BEREAVEMENT PROGRAM	0		0		0	60.00
61.00	VOLUNTEER PROGRAM	0		0		0	61.00
62.00	FUNDRAISING	0		0		0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63.00
64.00	PALLIATIVE CARE PROGRAM	0		0		0	64.00
65.00	OTHER PHYSICIAN SERVICES	0		0		0	65.00
66.00	RESIDENTIAL CARE	0	0	0	0	0	66.00
67.00	ADVERTISING	0		0		0	67.00
68.00	TELEHEALTH/TELEMONITORING	0		0		0	68.00
69.00	THRIFT STORE	0		0		0	69.00
70.00	NURSING FACILITY ROOM & BOARD						70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71.00
99.00	NEGATIVE COST CENTER						99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	0	0	0	0	55,589	100.00
101.00	UNIT COST MULTIPLIER	0.000000	0.000000	0.000000	0.000000	3.646137	101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 14-0179

Period:

Worksheet 0-6

Hospice CCN: 14-1511

From 07/01/2019
To 01/31/2020Part II
Date/Time Prepared:
7/28/2020 8:27 am

Cost Center Descriptions		Hospice I				
		ROUTINE MEDICAL SUPPLIES (PATIENT DAYS)	MEDICAL RECORDS (PATIENT DAYS)	STAFF TRANSPORTATION (MILEAGE)	VOLUNTEER SERVICE COORDINATION (HOURS OF SERVICE)	PHARMACY (CHARGES)
		10.00	11.00	12.00	13.00	14.00
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT					3.00
4.00	ADMINISTRATIVE & GENERAL					4.00
5.00	PLANT OPERATION & MAINTENANCE					5.00
6.00	LAUNDRY & LINEN SERVICE					6.00
7.00	HOUSEKEEPING					7.00
8.00	DIETARY					8.00
9.00	NURSING ADMINISTRATION					9.00
10.00	ROUTINE MEDICAL SUPPLIES	0				10.00
11.00	MEDICAL RECORDS		3,644			11.00
12.00	STAFF TRANSPORTATION			0		12.00
13.00	VOLUNTEER SERVICE COORDINATION			0	309	13.00
14.00	PHARMACY			0	0	100 14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES			0	0	0 15.00
16.00	OTHER GENERAL SERVICE			0	0	0 16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES					17.00
LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	3,486	0	0	0 50.00
51.00	HOSPICE ROUTINE HOME CARE	0	0	0	0	100 51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0	8	0 52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	158	0	301	0 53.00
NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM			0	0	0 60.00
61.00	VOLUNTEER PROGRAM			0	0	0 61.00
62.00	FUNDRAISING			0	0	0 62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			0	0	0 63.00
64.00	PALLIATIVE CARE PROGRAM			0	0	0 64.00
65.00	OTHER PHYSICIAN SERVICES			0	0	0 65.00
66.00	RESIDENTIAL CARE			0	0	0 66.00
67.00	ADVERTISING			0	0	0 67.00
68.00	TELEHEALTH/TELEMONITORING			0	0	0 68.00
69.00	THRIFT STORE			0	0	0 69.00
70.00	NURSING FACILITY ROOM & BOARD			0	0	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)			0	0	0 71.00
99.00	NEGATIVE COST CENTER					99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	0	10,969	0	50,177	15,589 100.00
101.00	UNIT COST MULTIPLIER	0.000000	3.010154	0.000000	162.385113	155.890000 101.00

COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS
STATISTICAL BASIS

Provider CCN: 14-0179

Period:

Worksheet 0-6

Hospice CCN: 14-1511

From 07/01/2019
To 01/31/2020Part II
Date/Time Prepared:
7/28/2020 8:27 am

Cost Center Descriptions		PHYSICIAN ADMINISTRATIVE SERVICES (PATIENT DAYS)	OTHER GENERAL SERVICE (SPECIFY BASIS)	PATIENT/ RESIDENTIAL CARE SERVICES (IN-FACILITY DAYS)	Hospice I	
		15.00	16.00	17.00		
GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT					1.00
2.00	CAP REL COSTS-MVBLE EQUIP					2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT					3.00
4.00	ADMINISTRATIVE & GENERAL					4.00
5.00	PLANT OPERATION & MAINTENANCE					5.00
6.00	LAUNDRY & LINEN SERVICE					6.00
7.00	HOUSEKEEPING					7.00
8.00	DIETARY					8.00
9.00	NURSING ADMINISTRATION					9.00
10.00	ROUTINE MEDICAL SUPPLIES					10.00
11.00	MEDICAL RECORDS					11.00
12.00	STAFF TRANSPORTATION					12.00
13.00	VOLUNTEER SERVICE COORDINATION					13.00
14.00	PHARMACY					14.00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0				15.00
16.00	OTHER GENERAL SERVICE		0			16.00
17.00	PATIENT/RESIDENTIAL CARE SERVICES			0		17.00
LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE	0	0			50.00
51.00	HOSPICE ROUTINE HOME CARE	0	0			51.00
52.00	HOSPICE INPATIENT RESPITE CARE	0	0	0		52.00
53.00	HOSPICE GENERAL INPATIENT CARE	0	0	0		53.00
NONREIMBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM		0			60.00
61.00	VOLUNTEER PROGRAM		0			61.00
62.00	FUNDRAISING		0			62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		0			63.00
64.00	PALLIATIVE CARE PROGRAM		0			64.00
65.00	OTHER PHYSICIAN SERVICES		0			65.00
66.00	RESIDENTIAL CARE	0	0	0		66.00
67.00	ADVERTISING		0			67.00
68.00	TELEHEALTH/TELEMONITORING		0			68.00
69.00	THRIFT STORE		0			69.00
70.00	NURSING FACILITY ROOM & BOARD		0			70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0		71.00
99.00	NEGATIVE COST CENTER		0	0		99.00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	0	0	0		100.00
101.00	UNIT COST MULTIPLIER	0.000000	0.000000	0.000000		101.00

APPORTIONMENT OF HOSPITAL-BASED HOSPICE SHARED SERVICE COSTS BY
LEVEL OF CARE

Provider CCN: 14-0179

Period:

Worksheet 0-7

Hospice CCN: 14-1511

From 07/01/2019
To 01/31/2020

Date/Time Prepared:
7/28/2020 8:27 am

			Hospice I		
Cost Center Descriptions	From Wkst. C, Part I, Col. 9 line	Cost to Charge Ratio	Charges by LOC (from Provider Records)		
			HCHC	HRHC	HIRC
	0	1.00	2.00	3.00	4.00
ANCILLARY SERVICE COST CENTERS					
1.00 PHYSICAL THERAPY	66.00	0.313789	0	0	0
2.00 OCCUPATIONAL THERAPY	67.00				
3.00 SPEECH PATHOLOGY	68.00	0.212231	0	0	0
4.00 DRUGS CHARGED TO PATIENTS	73.00	0.187162	0	0	0
5.00 DURABLE MEDICAL EQUIP-RENTED	96.00				
6.00 LABORATORY	60.00	0.098351	0	0	0
7.00 MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0.436735	0	0	0
8.00 OUTPATIENT REHAB	93.00	0.532045	0	0	0
8.10 WOUND CARE CENTER	93.10	0.382974	0	0	0
9.00 RADIOLOGY-THERAPEUTIC	55.00	0.343425	0	0	0
10.00 ENTEROSTOMAL THERAPY	76.00	0.000000	0	0	0
10.10 NEUROLOGY	76.10	0.000000	0	0	0
10.20 EMG	76.20	0.000000	0	0	0
10.30 OS SVCS	76.30	1.120544	0	0	0
10.40 AUDIOLOGY	76.40	0.000000	0	0	0
10.97 CARDIAC REHABILITATION	76.97	0.000000	0	0	0
10.98 HYPERBARIC OXYGEN THERAPY	76.98	0.000000	0	0	0
10.99 LITHOTRIPSY	76.99	0.000000	0	0	0
11.00 Totals (sum of lines 1-11)					
Cost Center Descriptions	Charges by LOC (from Provider Records)	Shared Service Costs by LOC			
	HGIP	HCHC (col. 1 x col. 2)	HRHC (col. 1 x col. 3)	HIRC (col. 1 x col. 4)	HGIP (col. 1 x col. 5)
	5.00	6.00	7.00	8.00	9.00
ANCILLARY SERVICE COST CENTERS					
1.00 PHYSICAL THERAPY	0	0	0	0	0
2.00 OCCUPATIONAL THERAPY					
3.00 SPEECH PATHOLOGY	0	0	0	0	0
4.00 DRUGS CHARGED TO PATIENTS	0	0	0	0	0
5.00 DURABLE MEDICAL EQUIP-RENTED					
6.00 LABORATORY	0	0	0	0	0
7.00 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0
8.00 OUTPATIENT REHAB	0	0	0	0	0
8.10 WOUND CARE CENTER	0	0	0	0	0
9.00 RADIOLOGY-THERAPEUTIC	0	0	0	0	0
10.00 ENTEROSTOMAL THERAPY	0	0	0	0	0
10.10 NEUROLOGY	0	0	0	0	0
10.20 EMG	0	0	0	0	0
10.30 OS SVCS	0	0	0	0	0
10.40 AUDIOLOGY	0	0	0	0	0
10.97 CARDIAC REHABILITATION	0	0	0	0	0
10.98 HYPERBARIC OXYGEN THERAPY	0	0	0	0	0
10.99 LITHOTRIPSY	0	0	0	0	0
11.00 Totals (sum of lines 1-11)		0	0	0	0

CALCULATION OF HOSPITAL-BASED HOSPICE PER DIEM COST

Provider CCN: 14-0179

Period:

Worksheet 0-8

Hospice CCN: 14-1511

From 07/01/2019
To 01/31/2020Date/Time Prepared:
7/28/2020 8:27 am

		Hospice I			
		TITLE XVIII MEDICARE	TITLE XIX MEDICAID	TOTAL	
		1.00	2.00	3.00	
HOSPICE CONTINUOUS HOME CARE					
1.00	Total cost (Wkst. 0-6, Part I, col. 18, line 50 plus Wkst. 0-7, col. 6, line 11)			922,362	1.00
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)			3,486	2.00
3.00	Total average cost per diem (line 1 divided by line 2)			264.59	3.00
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, line 10)	3,307	0		4.00
5.00	Program cost (line 3 times line 4)	874,999	0		5.00
HOSPICE ROUTINE HOME CARE					
6.00	Total cost (Wkst. 0-6, Part I, col. 18, line 51 plus Wkst. 0-7, col. 7, line 11)			67,386	6.00
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)			0	7.00
8.00	Total average cost per diem (line 6 divided by line 7)			0.00	8.00
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 11)	0	0		9.00
10.00	Program cost (line 8 times line 9)	0	0		10.00
HOSPICE INPATIENT RESPITE CARE					
11.00	Total cost (Wkst. 0-6, Part I, col. 18, line 52 plus Wkst. 0-7, col. 8, line 11)			1,299	11.00
12.00	Total unduplicated days (Wkst. S-9, col. 4, line 12)			0	12.00
13.00	Total average cost per diem (line 11 divided by line 12)			0.00	13.00
14.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 12)	0	0		14.00
15.00	Program cost (line 13 times line 14)	0	0		15.00
HOSPICE GENERAL INPATIENT CARE					
16.00	Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0-7, col. 9, line 11)			167,149	16.00
17.00	Total unduplicated days (Wkst. S-9, col. 4, line 13)			158	17.00
18.00	Total average cost per diem (line 16 divided by line 17)			1,057.91	18.00
19.00	Unduplicated program days (Wkst. S-9, col. as appropriate, line 13)	158	0		19.00
20.00	Program cost (line 18 times line 19)	167,150	0		20.00
TOTAL HOSPICE CARE					
21.00	Total cost (sum of line 1 + line 6 + line 11 + line 16)			1,158,196	21.00
22.00	Total unduplicated days (Wkst. S-9, col. 4, line 14)			3,644	22.00
23.00	Average cost per diem (line 21 divided by line 22)			317.84	23.00

CALCULATION OF CAPITAL PAYMENT

Provider CCN: 14-0179

Period:
From 07/01/2019
To 01/31/2020Worksheet L
Parts I-III
Date/Time Prepared:
7/28/2020 8:27 am

Title XVIII		Hospital	PPS
			1.00
PART I - FULLY PROSPECTIVE METHOD			
CAPITAL FEDERAL AMOUNT			
1.00	Capital DRG other than outlier	1,608,811	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	9,634	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)	147.25	3.00
4.00	Number of interns & residents (see instructions)	2.32	4.00
5.00	Indirect medical education percentage (see instructions)	0.44	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)	7,079	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	0.00	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	0.00	8.00
9.00	Sum of lines 7 and 8	0.00	9.00
10.00	Allowable disproportionate share percentage (see instructions)	0.00	10.00
11.00	Disproportionate share adjustment (see instructions)	0	11.00
12.00	Total prospective capital payments (see instructions)	1,625,524	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