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 05-31-2019

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-0008	Period: From 07/01/2017 To 06/30/2018	Worksheet S Parts I-III Date/Time Prepared: 11/29/2018 6:58 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 11/29/2018 Time: 6:58 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. [1] 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. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 4
12. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by GOTTLIEB MEMORIAL HOSPITAL (14-0008) for the cost reporting period beginning 07/01/2017 and ending 06/30/2018 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 Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	-64,028	-111,487	0	0	1.00
2.00	Subprovider - IPF	0	17,355	0		0	2.00
3.00	Subprovider - IRF	0	97,525	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	6,180	0		0	7.00
200.00	Total	0	57,032	-111,487	0	0	200.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I | Date/Time Prepared: 11/29/2018 6:55 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 8700 WEST NORTH AVENUE	PO Box:			1.00
2.00	City: MELROSE PARK	State: IL	Zip Code: 60160	County: COOK	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	GOTTLIEB MEMORIAL HOSPITAL	140008	16974	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF	GOTTLIEB MEMORIAL PSYCHIATRIC UNIT	14S008	16974	4	01/01/2007	N	P	N	4.00
5.00	Subprovider - IRF	GOTTLIEB MEMORIAL REHABILITATION UNI	14T008	16974	5	07/01/1999	N	P	O	5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF	GOTTLIEB SKILLED NURSING CARE	145526	16974		06/10/1985	N	P	N	9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
17.10	Hospital-Based (CORF) I									17.10
17.20	Hospital-Based (OPT) I									17.20
17.30	Hospital-Based (OOT) I									17.30
17.40	Hospital-Based (OSP) I									17.40
18.00	Renal Dialysis									18.00
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	07/01/2017	06/30/2018	20.00
21.00	Type of Control (see instructions)	2		21.00
	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	Y	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	1	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	881	460	1	3	1,730	0	24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I | Date/Time Prepared: 11/29/2018 6:55 pm

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	198	56	0	0	339		25.00

		Urban/Rural S	Date of Geogr	
		1.00	2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	2		26.00
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	2		27.00
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0		35.00

		Beginning:	Ending:	
		1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.			36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.	0		37.00
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)	N		37.01
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.			38.00

		Y/N	Y/N	
		1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(i) or (ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i) or (ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	Y			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.	N			57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00

		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
		1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)	N			60.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I | Date/Time Prepared: 11/29/2018 6:55 pm

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)						61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).						61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.06

		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.			0.00	0.00	61.20

		1.00	
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)		
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00	62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00	62.01
	Teaching Hospitals that Claim Residents in Nonprovider Settings		
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)	N	63.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.				
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I | Date/Time Prepared: 11/29/2018 6:55 pm

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
		1.00	2.00	3.00	
	Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010				
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000	66.00

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	67.00

		1.00	2.00	3.00	
	Inpatient Psychiatric Facility PPS				
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	Y			70.00
71.00	If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N		0	71.00
	Inpatient Rehabilitation Facility PPS				
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	Y			75.00
76.00	If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)	N		0	76.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I Date/Time Prepared: 11/29/2018 6:55 pm

		1.00	
	Long Term Care Hospital PPS		
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.	N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.	N	81.00
	TEFRA Providers		
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.	N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		86.00
87.00	Is this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	N	87.00

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.			107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.		N	N	N	109.00

		1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration)for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.	N	110.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I Date/Time Prepared: 11/29/2018 6:55 pm

		1.00	2.00	
111.00	If this facility qualifies as a CAH, did it participate in the Frontier Community Health Integration Project (FCHIP) demonstration for this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, enter the integration prong of the FCHIP demo in which this CAH is participating in column 2. Enter all that apply: "A" for Ambulance services; "B" for additional beds; and/or "C" for tele-health services.	N		111.00

		1.00	2.00	3.00	
	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.	Y			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00

		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	2,295,071	0	0	118.01

		1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02
119.00	DO NOT USE THIS LINE			119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00
122.00	Does the cost report contain healthcare related taxes as defined in §1903(w)(3) of the Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter in column 2 the Worksheet A line number where these taxes are included.	N		122.00
	Transplant Center Information			
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00
	All Providers			
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y	902022	140.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part I Date/Time Prepared: 11/29/2018 6:55 pm

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name: TRINITY HEALTH HOME OFFICE	Contractor's Name: WISCONSIN PHYSICIANS SERVICE	Contractor's Number: 08201	141.00
142.00	Street: 20555 VICTORY PARKWAY	PO Box:		142.00
143.00	City: LIVONIA	State: MI	Zip Code: 48152	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.			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.	Y	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)	0	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)	07/01/2016	06/30/2017	170.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-0008	Period: From 07/01/2017 To 06/30/2018	Worksheet S-2 Part I Date/Time Prepared: 11/29/2018 6:55 pm

		1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-0008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part II | Date/Time Prepared: 11/29/2018 6:55 pm

		Y/N	Date	
		1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.			
	COMPLETED BY ALL HOSPITALS			
	Provider Organization and Operation			
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N		1.00

		Y/N	Date	V/I	
		1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00

		Y/N	Type	Date	
		1.00	2.00	3.00	
	Financial Data and Reports				
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	09/30/2017	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00

		Y/N	Legal Oper.	
		1.00	2.00	
	Approved Educational Activities			
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	Y		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

		Y/N	
		1.00	
	Bad Debts		
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.	Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.	N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.	N	14.00
	Bed Complement		
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.	N	15.00

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		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	11/08/2017	Y	11/08/2017	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		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		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-0008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-2 Part II Date/Time Prepared: 11/29/2018 6:55 pm

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00

		1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)		
	Capital Related Cost		
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.		25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.		27.00
	Interest Expense		
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.		31.00
	Purchased Services		
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.		33.00
	Provider-Based Physicians		
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.		35.00

		Y/N	Date	
		1.00	2.00	
	Home Office Costs			
36.00	Were home office costs claimed on the cost report?			36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			40.00

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DAVID	PALUCK	41.00
42.00	Enter the employer/company name of the cost report preparer.	LOYOLA UNIVERSITY HEALTH SYSTEM		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	708-216-6719	DAVID.PALUCK@TRINITY-HEALTH.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-0008	Period: From 07/01/2017 To 06/30/2018	Worksheet S-2 Part II Date/Time Prepared: 11/29/2018 6:55 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-0008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part I | Date/Time Prepared: 11/29/2018 6:55 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	131	51,065	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)		131	51,065	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	24	8,760	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		155	59,825	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	12	4,380		0	16.00
17.00	SUBPROVIDER - IRF	41.00	21	7,665		0	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	44.00	34	12,410		0	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	99.10				0	25.10
25.20	CMHC - OUTPATIENT PHYSICAL THERAPY	99.20				0	25.20
25.30	CMHC - OUTPATIENT OCCUPATIONAL THERAPY	99.30				0	25.30
25.40	CMHC - OUTPATIENT SPEECH PATHOLOGY	99.40				0	25.40
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		222				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-0008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part I | Date/Time Prepared: 11/29/2018 6:55 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	9,685	669	19,145			1.00
2.00	HMO and other (see instructions)	3,913	2,193				2.00
3.00	HMO IPF Subprovider	137	0				3.00
4.00	HMO IRF Subprovider	606	395				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)	9,685	669	19,145			7.00
8.00	INTENSIVE CARE UNIT	1,660	213	3,834			8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		0	0			13.00
14.00	Total (see instructions)	11,345	882	22,979	3.31	697.66	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	3,078	8	3,379	0.00	16.84	16.00
17.00	SUBPROVIDER - IRF	2,986	198	5,510	0.00	28.58	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	6,334	153	9,221	0.00	35.37	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	0	0	0			24.10
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	0	0	0	0.00	0.00	25.10
25.20	CMHC - OUTPATIENT PHYSICAL THERAPY	0	0	0	0.00	0.00	25.20
25.30	CMHC - OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0.00	0.00	25.30
25.40	CMHC - OUTPATIENT SPEECH PATHOLOGY	0	0	0	0.00	0.00	25.40
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				3.31	778.45	27.00
28.00	Observation Bed Days		400	2,575			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			170			30.00
31.00	Employee discount days - IRF			85			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-0008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part I | Date/Time Prepared: 11/29/2018 6:55 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		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	2,437	712	5,284	1.00
2.00	HMO and other (see instructions)			806	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	2,437	712	5,284	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	196	2	223	16.00
17.00	SUBPROVIDER - IRF	0.00	0	232	33	421	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	0.00					25.10
25.20	CMHC - OUTPATIENT PHYSICAL THERAPY	0.00					25.20
25.30	CMHC - OUTPATIENT OCCUPATIONAL THERAPY	0.00					25.30
25.40	CMHC - OUTPATIENT SPEECH PATHOLOGY	0.00					25.40
26.00	RURAL HEALTH CLINIC						26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part II Date/Time Prepared: 11/29/2018 6:55 pm

		Wkst. A Line Number	Amount Reported	Reclassification 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	48,715,001	0	48,715,001	1,619,168.42	30.09	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	2,050,560	0	2,050,560	73,576.99	27.87	9.00
10.00	Excluded area salaries (see instructions)		3,556,740	0	3,556,740	112,777.39	31.54	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		1,610,158	0	1,610,158	27,193.00	59.21	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00	13.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		3,465,073	0	3,465,073	57,894.00	59.85	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		8,524,744	0	8,524,744			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		1,108,822	0	1,108,822			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		836,823	0	836,823			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	769,839	0	769,839	25,046.50	30.74	26.00
27.00	Administrative & General	5.00	2,979,712	0	2,979,712	140,931.61	21.14	27.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part II | Date/Time Prepared: 11/29/2018 6:55 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		399,569	0	399,569	3,900.00	102.45	28.00
29.00	Maintenance & Repairs	6.00	626,466	0	626,466	20,517.37	30.53	29.00
30.00	Operation of Plant	7.00	1,243,890	0	1,243,890	52,458.44	23.71	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	1,429,959	0	1,429,959	105,154.54	13.60	32.00
33.00	Housekeeping under contract (see instructions)		159,964	0	159,964	5,527.00	28.94	33.00
34.00	Dietary	10.00	1,039,869	-718,140	321,729	20,070.52	16.03	34.00
35.00	Dietary under contract (see instructions)		261,130	0	261,130	11,070.00	23.59	35.00
36.00	Cafeteria	11.00	33,619	718,140	751,759	48,089.65	15.63	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,714,349	0	1,714,349	33,593.23	51.03	38.00
39.00	Central Services and Supply	14.00	889,200	0	889,200	41,594.67	21.38	39.00
40.00	Pharmacy	15.00	2,167,326	0	2,167,326	47,486.86	45.64	40.00
41.00	Medical Records & Medical Records Library	16.00	1,504,295	0	1,504,295	49,451.48	30.42	41.00
42.00	Social Service	17.00	518,472	0	518,472	16,662.40	31.12	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part III Date/Time Prepared: 11/29/2018 6:55 pm

		Worksheet A Line Number	Amount Reported	Reclassification 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)		49,535,664	0	49,535,664	1,639,665.42	30.21	1.00
2.00	Excluded area salaries (see instructions)		5,607,300	0	5,607,300	186,354.38	30.09	2.00
3.00	Subtotal salaries (line 1 minus line 2)		43,928,364	0	43,928,364	1,453,311.04	30.23	3.00
4.00	Subtotal other wages & related costs (see inst.)		5,075,231	0	5,075,231	85,087.00	59.65	4.00
5.00	Subtotal wage-related costs (see inst.)		9,361,567	0	9,361,567	0.00	21.31	5.00
6.00	Total (sum of lines 3 thru 5)		58,365,162	0	58,365,162	1,538,398.04	37.94	6.00
7.00	Total overhead cost (see instructions)		15,737,659	0	15,737,659	621,554.27	25.32	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 14-0008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part IV Date/Time Prepared: 11/29/2018 6:55 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	2,270,926	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)	116,326	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	1,794,833	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	316,000	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	114,518	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)	224,873	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	1,111,288	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	2,918,061	17.00
18.00	Medicare Taxes - Employers Portion Only	682,450	18.00
19.00	Unemployment Insurance	11,837	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	72,453	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	9,633,565	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 14-0008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-3 Part V Date/Time Prepared: 11/29/2018 6:55 pm

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	0	1,610,158	1.00
2.00	Hospital	0	1,610,158	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	0	0	8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
16.10	Hospital-Based-CMHC 10	0	0	16.10
16.20	Hospital-Based-CMHC 20	0	0	16.20
16.30	Hospital-Based-CMHC 30	0	0	16.30
16.40	Hospital-Based-CMHC 40	0	0	16.40
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 14-0008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-7 | Date/Time Prepared: 11/29/2018 6:55 pm

		1.00	2.00	
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.	N		1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	N		2.00

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
3.00		RUX	0	0	0	3.00
4.00		RUL	0	0	0	4.00
5.00		RVX	0	0	0	5.00
6.00		RVL	0	0	0	6.00
7.00		RHX	0	0	0	7.00
8.00		RHL	0	0	0	8.00
9.00		RMX	0	0	0	9.00
10.00		RML	0	0	0	10.00
11.00		RLX	0	0	0	11.00
12.00		RUC	950	0	950	12.00
13.00		RUB	2,541	0	2,541	13.00
14.00		RUA	1,656	0	1,656	14.00
15.00		RVC	300	0	300	15.00
16.00		RVB	385	0	385	16.00
17.00		RVA	328	0	328	17.00
18.00		RHC	33	0	33	18.00
19.00		RHB	8	0	8	19.00
20.00		RHA	23	0	23	20.00
21.00		RMC	0	0	0	21.00
22.00		RMB	8	0	8	22.00
23.00		RMA	25	0	25	23.00
24.00		RLB	0	0	0	24.00
25.00		RLA	0	0	0	25.00
26.00		ES3	0	0	0	26.00
27.00		ES2	0	0	0	27.00
28.00		ES1	0	0	0	28.00
29.00		HE2	0	0	0	29.00
30.00		HE1	0	0	0	30.00
31.00		HD2	0	0	0	31.00
32.00		HD1	3	0	3	32.00
33.00		HC2	0	0	0	33.00
34.00		HC1	0	0	0	34.00
35.00		HB2	0	0	0	35.00
36.00		HB1	0	0	0	36.00
37.00		LE2	0	0	0	37.00
38.00		LE1	0	0	0	38.00
39.00		LD2	0	0	0	39.00
40.00		LD1	3	0	3	40.00
41.00		LC2	0	0	0	41.00
42.00		LC1	0	0	0	42.00
43.00		LB2	0	0	0	43.00
44.00		LB1	8	0	8	44.00
45.00		CE2	5	0	5	45.00
46.00		CE1	0	0	0	46.00
47.00		CD2	6	0	6	47.00
48.00		CD1	4	0	4	48.00
49.00		CC2	0	0	0	49.00
50.00		CC1	5	0	5	50.00
51.00		CB2	0	0	0	51.00
52.00		CB1	12	0	12	52.00
53.00		CA2	0	0	0	53.00
54.00		CA1	0	0	0	54.00
55.00		SE3	0	0	0	55.00
56.00		SE2	0	0	0	56.00
57.00		SE1	0	0	0	57.00
58.00		SSC	0	0	0	58.00
59.00		SSB	0	0	0	59.00
60.00		SSA	0	0	0	60.00
61.00		IB2	0	0	0	61.00
62.00		IB1	0	0	0	62.00
63.00		IA2	0	0	0	63.00
64.00		IA1	0	0	0	64.00
65.00		BB2	0	0	0	65.00
66.00		BB1	0	0	0	66.00
67.00		BA2	0	0	0	67.00
68.00		BA1	0	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA | Provider CCN: 14-0008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-7 | Date/Time Prepared: 11/29/2018 6:55 pm

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	9	0	9	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	2	0	2	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	20	0	20	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	0	0	0	199.00
200.00	TOTAL		6,334	0	6,334	200.00

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
		1.00	2.00	
	SNF SERVICES			
201.00	Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).	16974	16974	201.00

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1.00	2.00	3.00	
	A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)				
202.00	Staffing	0	0.00		202.00
203.00	Recruitment	0	0.00		203.00
204.00	Retention of employees	0	0.00		204.00
205.00	Training	13,515	0.07	Y	205.00
206.00	OTHER NON-TRAINING EXP	3,449,129	19.13	Y	206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	18,029,790			207.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-0008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet S-10 | Date/Time Prepared: 11/29/2018 6:55 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.200379	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	10,334,568	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?		3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?		4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	86,111,472	6.00
7.00	Medicaid cost (line 1 times line 6)	17,254,931	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)	6,920,363	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)	6,920,363	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)	1,908,119	749,871	2,657,990	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	382,347	749,871	1,132,218	21.00
22.00	Payments received from patients for amounts previously written off as charity care	1,283	41,823	43,106	22.00
23.00	Cost of charity care (line 21 minus line 22)	381,064	708,048	1,089,112	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)	9,596,535	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	467,212	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	718,787	27.01
28.00	Non-Medicare bad debt expense (see instructions)	8,877,748	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	2,030,489	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	3,119,601	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	10,039,964	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A | Date/Time Prepared: 11/29/2018 6:55 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		9,882,175	9,882,175	-4,441,480	5,440,695	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	5,061,127	5,061,127	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	769,839	7,277,392	8,047,231	-17,820	8,029,411	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	2,979,712	18,761,595	21,741,307	-876,232	20,865,075	5.00
6.00	00600	MAINTENANCE & REPAIRS	626,466	1,995,311	2,621,777	-8	2,621,769	6.00
7.00	00700	OPERATION OF PLANT	1,243,890	3,049,109	4,292,999	0	4,292,999	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	792,265	792,265	0	792,265	8.00
9.00	00900	HOUSEKEEPING	1,429,959	928,289	2,358,248	0	2,358,248	9.00
10.00	01000	DIETARY	1,039,869	860,556	1,900,425	-1,308,331	592,094	10.00
11.00	01100	CAFETERIA	33,619	27,242	60,861	1,308,331	1,369,192	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	1,714,349	499,874	2,214,223	0	2,214,223	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	889,200	-55,335	833,865	-9,660	824,205	14.00
15.00	01500	PHARMACY	2,167,326	2,935,899	5,103,225	-1,308,534	3,794,691	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,504,295	158,552	1,662,847	0	1,662,847	16.00
17.00	01700	SOCIAL SERVICE	518,472	164,274	682,746	-32	682,714	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	256,578	256,578	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	7,830,852	1,458,894	9,289,746	-629,971	8,659,775	30.00
31.00	03100	INTENSIVE CARE UNIT	2,790,018	744,275	3,534,293	-388,460	3,145,833	31.00
40.00	04000	SUBPROVIDER - IPF	1,031,977	108,380	1,140,357	-18,235	1,122,122	40.00
41.00	04100	SUBPROVIDER - IRF	1,956,778	350,672	2,307,450	-139,199	2,168,251	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	2,050,560	1,412,084	3,462,644	-119,375	3,343,269	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,041,448	10,340,849	13,382,297	-8,619,408	4,762,889	50.00
51.00	05100	RECOVERY ROOM	353,354	215,815	569,169	-41,049	528,120	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	355,106	355,106	-346,520	8,586	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,718,478	250,968	1,969,446	-70,025	1,899,421	54.00
56.00	05600	RADIOISOTOPE	179,528	238,948	418,476	-224,680	193,796	56.00
56.01	03630	ULTRASOUND	487,854	-42,334	445,520	-17,414	428,106	56.01
57.00	05700	CT SCAN	458,433	156,249	614,682	-128,889	485,793	57.00
58.00	05800	MRI	185,077	111,961	297,038	-65,235	231,803	58.00
59.00	05900	CARDIAC CATHETERIZATION	546,057	1,633,394	2,179,451	-1,408,447	771,004	59.00
60.00	06000	LABORATORY	2,258,476	2,597,236	4,855,712	498,384	5,354,096	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,061,504	207,861	1,269,365	-102,878	1,166,487	65.00
66.00	06600	PHYSICAL THERAPY	2,131,096	112,767	2,243,863	-13,606	2,230,257	66.00
67.00	06700	OCCUPATIONAL THERAPY	276,741	12,764	289,505	-509	288,996	67.00
68.00	06800	SPEECH PATHOLOGY	224,241	70,188	294,429	-58,902	235,527	68.00
69.00	06900	ELECTROCARDIOLOGY	398,852	110,132	508,984	-23,380	485,604	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	111,193	12,201	123,394	-7,137	116,257	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	7,423,543	7,423,543	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	5,777,563	5,777,563	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,047,143	1,047,143	73.00
73.01	07301	OUTPATIENT PHARMACY	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	LITHOTRIPSY	0	0	0	0	0	76.00
76.01	03951	CARDIAC REHABILITATION	200,205	15,688	215,893	-3,081	212,812	76.01
76.02	03020	GASTROINTESTINAL SERVICES	639,874	603,190	1,243,064	-332,877	910,187	76.02
76.03	03030	ANGIOCARDIOGRAPHY	0	0	0	0	0	76.03
76.05	03954	INPATIENT RENAL DIALYSIS	0	0	0	0	0	76.05
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES	0	0	0	0	0	90.01
90.02	04950	WOUND CARE	258,346	793,886	1,052,232	-119,159	933,073	90.02
90.03	09003	RIVER FOREST	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	3,039,078	1,005,966	4,045,044	-532,136	3,512,908	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A | Date/Time Prepared: 11/29/2018 6:55 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	48,147,016	70,154,338	118,301,354	0	118,301,354	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	28,514	94,350	122,864	0	122,864	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	NON-EMPLOYEE CHILD CARE CENTER	0	0	0	0	0	192.01
192.02	19202	OUTPATIENT PHARMACY	374,052	1,117,419	1,491,471	0	1,491,471	192.02
192.03	19203	WEST TOWN PHO	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	26,293	26,293	0	26,293	193.00
193.01	19301	ADULT DAY CARE	165,419	30,103	195,522	0	195,522	193.01
194.00	07950	DISCONTINUED HOME HEALTH AND HOSPICE	0	14,804	14,804	0	14,804	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	48,715,001	71,437,307	120,152,308	0	120,152,308	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A | Date/Time Prepared: 11/29/2018 6:55 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-532,298	4,908,397		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	5,061,127		2.00
3.00	00300	OTHER CAP REL COSTS	0	0		3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-183,161	7,846,250		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-1,865,639	18,999,436		5.00
6.00	00600	MAINTENANCE & REPAIRS	0	2,621,769		6.00
7.00	00700	OPERATION OF PLANT	0	4,292,999		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	792,265		8.00
9.00	00900	HOUSEKEEPING	0	2,358,248		9.00
10.00	01000	DIETARY	-49,014	543,080		10.00
11.00	01100	CAFETERIA	-176,935	1,192,257		11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0		12.00
13.00	01300	NURSING ADMINISTRATION	-727	2,213,496		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	824,205		14.00
15.00	01500	PHARMACY	0	3,794,691		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-29,977	1,632,870		16.00
17.00	01700	SOCIAL SERVICE	8,058	690,772		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0		19.00
20.00	02000	NURSING SCHOOL	0	0		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	-1,805	254,773		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-707	8,659,068		30.00
31.00	03100	INTENSIVE CARE UNIT	0	3,145,833		31.00
40.00	04000	SUBPROVIDER - IPF	0	1,122,122		40.00
41.00	04100	SUBPROVIDER - IRF	0	2,168,251		41.00
43.00	04300	NURSERY	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	0	3,343,269		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	4,762,889		50.00
51.00	05100	RECOVERY ROOM	0	528,120		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	8,586		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,899,421		54.00
56.00	05600	RADIOISOTOPE	0	193,796		56.00
56.01	03630	ULTRASOUND	0	428,106		56.01
57.00	05700	CT SCAN	0	485,793		57.00
58.00	05800	MRI	0	231,803		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	771,004		59.00
60.00	06000	LABORATORY	0	5,354,096		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	0	1,166,487		65.00
66.00	06600	PHYSICAL THERAPY	0	2,230,257		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	288,996		67.00
68.00	06800	SPEECH PATHOLOGY	-50	235,477		68.00
69.00	06900	ELECTROCARDIOLOGY	0	485,604		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	116,257		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	7,423,543		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,777,563		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,047,143		73.00
73.01	07301	OUTPATIENT PHARMACY	0	0		73.01
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	LITHOTRIPSY	0	0		76.00
76.01	03951	CARDIAC REHABILITATION	0	212,812		76.01
76.02	03020	GASTROINTESTINAL SERVICES	0	910,187		76.02
76.03	03030	ANGIOCARDIOGRAPHY	0	0		76.03
76.05	03954	INPATIENT RENAL DIALYSIS	0	0		76.05
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0		76.99
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES	0	0		90.01
90.02	04950	WOUND CARE	0	933,073		90.02
90.03	09003	RIVER FOREST	0	0		90.03
91.00	09100	EMERGENCY	0	3,512,908		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
99.10	09910	CORF	0	0		99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0		99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0		99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0		99.40

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A | Date/Time Prepared: 11/29/2018 6:55 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-2,832,255	115,469,099	118.00
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	122,864	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
192.01	19201	NON-EMPLOYEE CHILD CARE CENTER	0	0	192.01
192.02	19202	OUTPATIENT PHARMACY	0	1,491,471	192.02
192.03	19203	WEST TOWN PHO	0	0	192.03
193.00	19300	NONPAID WORKERS	0	26,293	193.00
193.01	19301	ADULT DAY CARE	0	195,522	193.01
194.00	07950	DISCONTINUED HOME HEALTH AND HOSPICE	0	14,804	194.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-2,832,255	117,320,053	200.00

RECLASSIFICATIONS | Provider CCN: 14-0008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-6 | Date/Time Prepared: 11/29/2018 6:55 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - Drugs Charged to Patients				
1.00	ULTRASOUND	56.01	0	15,218	1.00
2.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,047,143	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
	0		0	1,062,361	
	C - Dietary Shared Cost				
1.00	CAFETERIA	11.00	718,140	590,191	1.00
	0		718,140	590,191	
	E - Interns and Residents				
1.00	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	0	256,578	1.00
	0		0	256,578	
	F - Blood Transfusion				
1.00	LABORATORY	60.00	0	588,226	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
	0		0	588,226	
	I - Medical Supplies Charged to Patients				
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	7,423,543	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
	0		0	7,423,543	
	L - Implantable Devices				
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	5,777,563	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00

RECLASSIFICATIONS | Provider CCN: 14-0008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-6 | Date/Time Prepared: 11/29/2018 6:55 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5.00
6.00		0.00	0	0		6.00
	0		0	5,777,563		
	N - Capital Movable Equipment					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	5,061,127		1.00
	0		0	5,061,127		
	O - Interest Expense					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	619,647		1.00
	0		0	619,647		
500.00	Grand Total: Increases		718,140	21,379,236		500.00

RECLASSIFICATIONS | Provider CCN: 14-0008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-6 | Date/Time Prepared: 11/29/2018 6:55 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - Drugs Charged to Patients						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	17,820	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	7	0		2.00
3.00	MAINTENANCE & REPAIRS	6.00	0	8	0		3.00
4.00	CENTRAL SERVICES & SUPPLY	14.00	0	1,822	0		4.00
5.00	PHARMACY	15.00	0	720,710	0		5.00
6.00	ADULTS & PEDIATRICS	30.00	0	47,963	0		6.00
7.00	INTENSIVE CARE UNIT	31.00	0	17,997	0		7.00
8.00	SUBPROVIDER - IPF	40.00	0	258	0		8.00
9.00	SUBPROVIDER - IRF	41.00	0	1,568	0		9.00
10.00	SKILLED NURSING FACILITY	44.00	0	3,852	0		10.00
11.00	OPERATING ROOM	50.00	0	92,504	0		11.00
12.00	RECOVERY ROOM	51.00	0	3,393	0		12.00
13.00	ANESTHESIOLOGY	53.00	0	57,589	0		13.00
14.00	RADIOLOGY-DIAGNOSTIC	54.00	0	2,153	0		14.00
15.00	RADIOISOTOPE	56.00	0	216	0		15.00
16.00	CT SCAN	57.00	0	80	0		16.00
17.00	MRI	58.00	0	31,133	0		17.00
18.00	CARDIAC CATHETERIZATION	59.00	0	2,525	0		18.00
19.00	LABORATORY	60.00	0	4	0		19.00
20.00	RESPIRATORY THERAPY	65.00	0	537	0		20.00
21.00	PHYSICAL THERAPY	66.00	0	238	0		21.00
22.00	OCCUPATIONAL THERAPY	67.00	0	2	0		22.00
23.00	ELECTROCARDIOLOGY	69.00	0	271	0		23.00
24.00	CARDIAC REHABILITATION	76.01	0	4	0		24.00
25.00	GASTROINTESTINAL SERVICES	76.02	0	11,788	0		25.00
26.00	WOUND CARE	90.02	0	572	0		26.00
27.00	EMERGENCY	91.00	0	47,347	0		27.00
	0		0	1,062,361			
	C - Dietary Shared Cost						
1.00	DIETARY	10.00	718,140	590,191	0		1.00
	0		718,140	590,191			
	E - Interns and Residents						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	256,578	0		1.00
	0		0	256,578			
	F - Blood Transfusion						
1.00	PHARMACY	15.00	0	587,824	0		1.00
2.00	SOCIAL SERVICE	17.00	0	32	0		2.00
3.00	ULTRASOUND	56.01	0	370	0		3.00
	0		0	588,226			
	I - Medical Supplies Charged to Patients						
1.00	ADULTS & PEDIATRICS	30.00	0	582,007	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	370,463	0		2.00
3.00	SUBPROVIDER - IPF	40.00	0	17,977	0		3.00
4.00	SUBPROVIDER - IRF	41.00	0	137,631	0		4.00
5.00	SKILLED NURSING FACILITY	44.00	0	115,523	0		5.00
6.00	OPERATING ROOM	50.00	0	3,308,732	0		6.00
7.00	RECOVERY ROOM	51.00	0	37,656	0		7.00
8.00	ANESTHESIOLOGY	53.00	0	288,931	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	67,872	0		9.00
10.00	RADIOISOTOPE	56.00	0	224,464	0		10.00
11.00	ULTRASOUND	56.01	0	32,262	0		11.00
12.00	CT SCAN	57.00	0	128,809	0		12.00
13.00	MRI	58.00	0	34,102	0		13.00
14.00	CARDIAC CATHETERIZATION	59.00	0	928,409	0		14.00
15.00	LABORATORY	60.00	0	89,838	0		15.00
16.00	RESPIRATORY THERAPY	65.00	0	102,341	0		16.00
17.00	PHYSICAL THERAPY	66.00	0	13,368	0		17.00
18.00	OCCUPATIONAL THERAPY	67.00	0	507	0		18.00
19.00	SPEECH PATHOLOGY	68.00	0	58,902	0		19.00
20.00	ELECTROCARDIOLOGY	69.00	0	23,109	0		20.00
21.00	ELECTROENCEPHALOGRAPHY	70.00	0	7,137	0		21.00
22.00	CARDIAC REHABILITATION	76.01	0	3,077	0		22.00
23.00	GASTROINTESTINAL SERVICES	76.02	0	315,008	0		23.00
24.00	WOUND CARE	90.02	0	50,629	0		24.00
25.00	EMERGENCY	91.00	0	484,789	0		25.00
	0		0	7,423,543			
	L - Implantable Devices						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	7,838	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	1	0		2.00
3.00	OPERATING ROOM	50.00	0	5,218,172	0		3.00
4.00	CARDIAC CATHETERIZATION	59.00	0	477,513	0		4.00
5.00	GASTROINTESTINAL SERVICES	76.02	0	6,081	0		5.00
6.00	WOUND CARE	90.02	0	67,958	0		6.00

RECLASSIFICATIONS | Provider CCN: 14-0008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-6 | Date/Time Prepared: 11/29/2018 6:55 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	0		0	5,777,563			
	N - Capital Movable Equipment						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	5,061,127	9		1.00
	0		0	5,061,127			
	O - Interest Expense						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	619,647	11		1.00
	0		0	619,647			
500.00	Grand Total: Decreases		718,140	21,379,236			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-7 Part I | Date/Time Prepared: 11/29/2018 6:55 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	12,500,000	0	0	0	0	1.00
2.00	Land Improvements	1,005,174	239,234	0	239,234	0	2.00
3.00	Buildings and Fixtures	54,865,863	15,932	0	15,932	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	14,513,641	920,995	0	920,995	5,720	5.00
6.00	Movable Equipment	43,896,670	3,351,490	0	3,351,490	418,607	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	126,781,348	4,527,651	0	4,527,651	424,327	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	126,781,348	4,527,651	0	4,527,651	424,327	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	12,500,000	0	1.00
2.00	Land Improvements	1,244,408	0	2.00
3.00	Buildings and Fixtures	54,881,795	0	3.00
4.00	Building Improvements	0	0	4.00
5.00	Fixed Equipment	15,428,916	0	5.00
6.00	Movable Equipment	46,829,553	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	130,884,672	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	130,884,672	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-7 Part II | Date/Time Prepared: 11/29/2018 6:55 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	9,882,175	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	9,882,175	0	0	0	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL		
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)	
		14.00	15.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	9,882,175	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	2.00
3.00	Total (sum of lines 1-2)	0	9,882,175	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-7 Part III Date/Time Prepared: 11/29/2018 6:55 pm

	Cost Center Description	COMPUTATION OF RATIOS: Gross Assets	COMPUTATION OF RATIOS: Capitalized Leases	COMPUTATION OF RATIOS: Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL: Ratio (see instructions)	ALLOCATION OF OTHER CAPITAL: 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	84,055,119	0	84,055,119	0.642208	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	46,829,553	0	46,829,553	0.357792	0	2.00
3.00	Total (sum of lines 1-2)	130,884,672	0	130,884,672	1.000000	0	3.00

	Cost Center Description	ALLOCATION OF OTHER CAPITAL: Taxes	ALLOCATION OF OTHER CAPITAL: Other Capital-Related Costs	ALLOCATION OF OTHER CAPITAL: Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL: Depreciation	SUMMARY OF CAPITAL: Lease	
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	4,821,048	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	5,061,127	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	9,882,175	0	3.00

	Cost Center Description	SUMMARY OF CAPITAL: Interest	SUMMARY OF CAPITAL: Insurance (see instructions)	SUMMARY OF CAPITAL: Taxes (see instructions)	SUMMARY OF CAPITAL: Other Capital-Related Costs (see instructions)	SUMMARY OF CAPITAL: 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	87,349	0	0	0	4,908,397	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	5,061,127	2.00
3.00	Total (sum of lines 1-2)	87,349	0	0	0	9,969,524	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8 | Date/Time Prepared: 11/29/2018 6:55 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	A	-36,080	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	-50,360			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	6,832,396			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests	B	-176,935	CAFETERIA	11.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts	B	-29,977	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	0	CAFETERIA	11.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8 | Date/Time Prepared: 11/29/2018 6:55 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.00
35.07	MISC INCOME A&G	B	-3,413,979	ADMINISTRATIVE & GENERAL	5.00	0	35.07
35.08	MISC OTHER INCOME AUDIOLOGY	B	-50	SPEECH PATHOLOGY	68.00	0	35.08
35.09	MISC OTHER INCOME BIRTH CENTER	B	-707	ADULTS & PEDIATRICS	30.00	0	35.09
35.10	GIFT NET ASSET RELEASE FROM RESTR	B	-15,000	ADMINISTRATIVE & GENERAL	5.00	0	35.10
35.15	WEST TOWNS 958.729	A	-478,121	ADMINISTRATIVE & GENERAL	5.00	0	35.15
35.19	EMPLOYEE DAY CARE REVENUE	B	-394,024	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	35.19
37.00	DIETARY	B	-49,014	DIETARY	10.00	0	37.00
39.00	BPCI Gain/Loss	A	8,058	SOCIAL SERVICE	17.00	0	39.00
40.00	Grants & Gifts	A	-950	ADMINISTRATIVE & GENERAL	5.00	0	40.00
41.00	ADVERTISING	A	-86,016	ADMINISTRATIVE & GENERAL	5.00	0	41.00
42.00	MISC NURSING DEVELOPMENT	B	-727	NURSING ADMINISTRATION	13.00	0	42.00
42.01	HAIP/ACA PROGRAM BENEFIT OFFSET	A	-4,940,769	ADMINISTRATIVE & GENERAL	5.00	0	42.01
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,832,255				50.00

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 14-0008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8-1 | Date/Time Prepared: 11/29/2018 6:55 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	INTERCOMPANY LOAN AND CAP	0	619,647	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	ADMIN OTHER OPERATING EXP	4,510,327	4,633,742	2.00
3.00	1.00	CAP REL COSTS-BLDG & FIXT	TIS CAPITAL EXPENSE	87,349	0	3.00
3.01	5.00	ADMINISTRATIVE & GENERAL	TIS OPERATING EXPENSE	2,481,713	70	3.01
3.02	5.00	ADMINISTRATIVE & GENERAL	MALPRACTICE INSURANCE	3,783,819	0	3.02
3.03	4.00	EMPLOYEE BENEFITS DEPARTMENT	WORKERS COMPENSATION INS	1,111,288	774,861	3.03
3.04	5.00	ADMINISTRATIVE & GENERAL	PROPERTY INSURANCE	101,050	0	3.04
3.05	5.00	ADMINISTRATIVE & GENERAL	INTEGRATED RISK INSURANCE	176,985	0	3.05
3.07	4.00	EMPLOYEE BENEFITS DEPARTMENT	EMP HEALTH STOP LOSS	0	125,564	3.07
3.08	22.00	I&R SERVICES-OTHER PRGM COST	ACO Admin - Residents	0	1,805	3.08
3.09	5.00	ADMINISTRATIVE & GENERAL	I/C THCE REPAIRS AND MAINT	0	1,388,405	3.09
3.10	5.00	ADMINISTRATIVE & GENERAL	IC DEFINED BENEFIT	0	-2,123,959	3.10
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			12,252,531	5,420,135	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		
	Symbol (1)	Name	Percentage of Ownership	Name	Percentage of Ownership	
	1.00	2.00	3.00	4.00	5.00	
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:					

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

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

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

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 14-0008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8-1 | Date/Time Prepared: 11/29/2018 6:55 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	-619,647	11		1.00
2.00	-123,415	0		2.00
3.00	87,349	11		3.00
3.01	2,481,643	0		3.01
3.02	3,783,819	0		3.02
3.03	336,427	0		3.03
3.04	101,050	0		3.04
3.05	176,985	0		3.05
3.07	-125,564	0		3.07
3.08	-1,805	0		3.08
3.09	-1,388,405	0		3.09
3.10	2,123,959	0		3.10
4.00	0	0		4.00
5.00	6,832,396			5.00

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

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

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

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

6.00	HEALTHCARE SYSTEM		6.00
7.00			7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 14-0008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet A-8-2 | Date/Time Prepared: 11/29/2018 6:55 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	50,360	50,360	0	211,500	0	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			50,360	50,360	0		0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	50,360		1.00
2.00	0.00		0	0	0	0		2.00
3.00	0.00		0	0	0	0		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	50,360		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I Date/Time Prepared: 11/29/2018 6:55 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	4,908,397	4,908,397				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	5,061,127		5,061,127			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	7,846,250	123,926	0	7,970,176		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	18,999,436	356,050	0	495,332	19,850,818	5.00
6.00	00600	MAINTENANCE & REPAIRS	2,621,769	27,622	0	104,141	2,753,532	6.00
7.00	00700	OPERATION OF PLANT	4,292,999	1,153,586	0	206,778	5,653,363	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	792,265	18,989	0	0	811,254	8.00
9.00	00900	HOUSEKEEPING	2,358,248	25,082	0	237,709	2,621,039	9.00
10.00	01000	DIETARY	543,080	103,604	0	53,483	700,167	10.00
11.00	01100	CAFETERIA	1,192,257	89,710	0	124,969	1,406,936	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	2,213,496	28,747	0	284,985	2,527,228	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	824,205	111,114	0	147,816	1,083,135	14.00
15.00	01500	PHARMACY	3,794,691	38,074	0	360,285	4,193,050	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,632,870	38,754	0	250,066	1,921,690	16.00
17.00	01700	SOCIAL SERVICE	690,772	2,776	0	86,188	779,736	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	254,773	0	0	0	254,773	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	8,659,068	612,174	5,061,127	1,301,774	15,634,143	30.00
31.00	03100	INTENSIVE CARE UNIT	3,145,833	152,686	0	463,799	3,762,318	31.00
40.00	04000	SUBPROVIDER - IPF	1,122,122	69,639	0	171,551	1,363,312	40.00
41.00	04100	SUBPROVIDER - IRF	2,168,251	154,837	0	325,285	2,648,373	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	3,343,269	166,816	0	340,875	3,850,960	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,762,889	540,356	0	505,595	5,808,840	50.00
51.00	05100	RECOVERY ROOM	528,120	21,057	0	58,740	607,917	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	8,586	8,564	0	0	17,150	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,899,421	139,388	0	285,671	2,324,480	54.00
56.00	05600	RADIOISOTOPE	193,796	26,401	0	29,844	250,041	56.00
56.01	03630	ULTRASOUND	428,106	26,567	0	81,098	535,771	56.01
57.00	05700	CT SCAN	485,793	16,907	0	76,208	578,908	57.00
58.00	05800	MRI	231,803	32,605	0	30,766	295,174	58.00
59.00	05900	CARDIAC CATHETERIZATION	771,004	28,636	0	90,774	890,414	59.00
60.00	06000	LABORATORY	5,354,096	136,279	0	375,438	5,865,813	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,166,487	15,171	0	176,459	1,358,117	65.00
66.00	06600	PHYSICAL THERAPY	2,230,257	137,195	0	354,263	2,721,715	66.00
67.00	06700	OCCUPATIONAL THERAPY	288,996	22,972	0	46,004	357,972	67.00
68.00	06800	SPEECH PATHOLOGY	235,477	13,603	0	37,277	286,357	68.00
69.00	06900	ELECTROCARDIOLOGY	485,604	28,566	0	66,303	580,473	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	116,257	14,477	0	18,484	149,218	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,423,543	0	0	0	7,423,543	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,777,563	0	0	0	5,777,563	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,047,143	0	0	0	1,047,143	73.00
73.01	07301	OUTPATIENT PHARMACY	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	LITHOTRIPSY	0	0	0	0	0	76.00
76.01	03951	CARDIAC REHABILITATION	212,812	50,095	0	33,281	296,188	76.01
76.02	03020	GASTROINTESTINAL SERVICES	910,187	54,259	0	106,369	1,070,815	76.02
76.03	03030	ANGIOCARDIOGRAPHY	0	0	0	0	0	76.03
76.05	03954	INPATIENT RENAL DIALYSIS	0	0	0	0	0	76.05
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES	0	0	0	0	0	90.01
90.02	04950	WOUND CARE	933,073	31,342	0	42,946	1,007,361	90.02
90.03	09003	RIVER FOREST	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	3,512,908	158,072	0	505,201	4,176,181	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I Date/Time Prepared: 11/29/2018 6:55 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	115,469,099	4,776,698	5,061,127	7,875,757	115,242,981	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	122,864	60,797	0	4,740	188,401	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	NON-EMPLOYEE CHILD CARE CENTER	0	0	0	0	0	192.01
192.02	19202	OUTPATIENT PHARMACY	1,491,471	27,567	0	62,181	1,581,219	192.02
192.03	19203	WEST TOWN PHO	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	26,293	21,404	0	0	47,697	193.00
193.01	19301	ADULT DAY CARE	195,522	21,931	0	27,498	244,951	193.01
194.00	07950	DISCONTINUED HOME HEALTH AND HOSPICE	14,804	0	0	0	14,804	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)	117,320,053	4,908,397	5,061,127	7,970,176	117,320,053	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I | Date/Time Prepared: 11/29/2018 6:55 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	19,850,818					5.00
6.00	00600	MAINTENANCE & REPAIRS	560,790	3,314,322				6.00
7.00	00700	OPERATION OF PLANT	1,151,375	868,785	7,673,523			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	165,222	14,301	44,872	1,035,649		8.00
9.00	00900	HOUSEKEEPING	533,806	18,890	59,272	86,663	3,319,670	9.00
10.00	01000	DIETARY	142,597	78,026	244,828	14,973	107,373	10.00
11.00	01100	CAFETERIA	286,539	67,562	211,994	0	92,973	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	514,700	21,650	67,931	0	29,792	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	220,593	83,682	262,574	30,827	115,156	14.00
15.00	01500	PHARMACY	853,965	28,674	89,974	6,687	39,459	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	391,375	29,187	91,581	0	40,164	16.00
17.00	01700	SOCIAL SERVICE	158,803	2,091	6,560	0	2,877	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	51,888	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	3,184,122	461,039	1,446,634	150,068	634,447	30.00
31.00	03100	INTENSIVE CARE UNIT	766,241	114,991	360,814	114,189	158,241	31.00
40.00	04000	SUBPROVIDER - IPF	277,655	52,446	164,564	0	72,172	40.00
41.00	04100	SUBPROVIDER - IRF	539,373	116,611	365,898	32,211	160,470	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	784,294	125,632	394,205	23,454	172,885	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,183,040	406,952	1,276,920	441,376	560,013	50.00
51.00	05100	RECOVERY ROOM	123,810	15,858	49,759	0	21,823	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	3,493	6,450	20,238	0	8,876	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	473,408	104,976	329,390	624	144,459	54.00
56.00	05600	RADIOISOTOPE	50,924	19,883	62,388	1,150	27,361	56.00
56.01	03630	ULTRASOUND	109,116	20,008	62,782	8,847	27,534	56.01
57.00	05700	CT SCAN	117,902	12,733	39,952	95	17,522	57.00
58.00	05800	MRI	60,116	24,556	77,050	0	33,792	58.00
59.00	05900	CARDIAC CATHETERIZATION	181,343	21,566	67,669	2,655	29,677	59.00
60.00	06000	LABORATORY	1,194,643	102,634	322,043	103,896	141,237	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	276,597	11,426	35,852	0	15,723	65.00
66.00	06600	PHYSICAL THERAPY	554,310	103,324	324,207	129	142,186	66.00
67.00	06700	OCCUPATIONAL THERAPY	72,905	17,301	54,286	0	23,808	67.00
68.00	06800	SPEECH PATHOLOGY	58,320	10,245	32,145	0	14,098	68.00
69.00	06900	ELECTROCARDIOLOGY	118,220	21,514	67,505	574	29,605	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	30,390	10,903	34,212	0	15,004	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,511,894	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,176,670	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	213,263	0	0	0	0	73.00
73.01	07301	OUTPATIENT PHARMACY	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	LITHOTRIPSY	0	0	0	0	0	76.00
76.01	03951	CARDIAC REHABILITATION	60,322	37,727	118,380	0	51,917	76.01
76.02	03020	GASTROINTESTINAL SERVICES	218,084	40,863	128,220	10,480	56,233	76.02
76.03	03030	ANGIOCARDIOGRAPHY	0	0	0	0	0	76.03
76.05	03954	INPATIENT RENAL DIALYSIS	0	0	0	0	0	76.05
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES	0	0	0	0	0	90.01
90.02	04950	WOUND CARE	205,161	23,604	74,065	116	32,482	90.02
90.03	09003	RIVER FOREST	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	850,529	119,047	373,541	3,148	163,822	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I Date/Time Prepared: 11/29/2018 6:55 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	19,427,798	3,215,137	7,362,305	1,032,162	3,183,181	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	38,370	45,787	143,669	0	63,008	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	NON-EMPLOYEE CHILD CARE CENTER	0	0	0	0	0	192.01
192.02	19202	OUTPATIENT PHARMACY	322,034	20,761	65,143	0	28,570	192.02
192.03	19203	WEST TOWN PHO	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	9,714	16,120	50,580	3,487	22,182	193.00
193.01	19301	ADULT DAY CARE	49,887	16,517	51,826	0	22,729	193.01
194.00	07950	DISCONTINUED HOME HEALTH AND HOSPICE	3,015	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)	19,850,818	3,314,322	7,673,523	1,035,649	3,319,670	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I Date/Time Prepared: 11/29/2018 6:55 pm

		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	1,287,964					10.00
11.00	01100	CAFETERIA	644,778	2,710,782				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	75,871	0	3,237,172		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	94,785	0	0	1,890,752	14.00
15.00	01500	PHARMACY	0	108,541	0	0	24,955	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	113,108	0	31,320	550	16.00
17.00	01700	SOCIAL SERVICE	0	38,365	0	0	51	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	109	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	208,519	540,182	0	1,238,164	11,803	30.00
31.00	03100	INTENSIVE CARE UNIT	37,236	148,787	0	376,523	5,515	31.00
40.00	04000	SUBPROVIDER - IPF	32,551	81,943	0	169,456	450	40.00
41.00	04100	SUBPROVIDER - IRF	53,910	136,482	0	298,976	2,530	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	66,271	169,528	0	347,392	2,543	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	197,254	0	225,258	60,932	50.00
51.00	05100	RECOVERY ROOM	0	17,893	0	38,022	299	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	1,296	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	117,837	0	23,114	1,235	54.00
56.00	05600	RADIOISOTOPE	0	8,490	0	0	212	56.00
56.01	03630	ULTRASOUND	0	25,523	0	0	405	56.01
57.00	05700	CT SCAN	0	25,738	0	0	721	57.00
58.00	05800	MRI	0	9,941	0	0	369	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	25,684	0	1,641	4,537	59.00
60.00	06000	LABORATORY	0	181,833	0	0	193,189	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	71,250	0	0	4,757	65.00
66.00	06600	PHYSICAL THERAPY	0	143,629	0	0	233	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	14,884	0	0	1	67.00
68.00	06800	SPEECH PATHOLOGY	0	15,475	0	0	16	68.00
69.00	06900	ELECTROCARDIOLOGY	0	30,305	0	137	309	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	9,027	0	0	15	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	874,240	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	680,425	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	OUTPATIENT PHARMACY	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	LITHOTRIPSY	0	0	0	0	0	76.00
76.01	03951	CARDIAC REHABILITATION	0	11,875	0	12,856	145	76.01
76.02	03020	GASTROINTESTINAL SERVICES	0	37,989	0	70,025	4,453	76.02
76.03	03030	ANGIOCARDIOGRAPHY	0	0	0	0	0	76.03
76.05	03954	INPATIENT RENAL DIALYSIS	0	0	0	0	0	76.05
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES	0	0	0	0	0	90.01
90.02	04950	WOUND CARE	0	15,690	0	39,800	2,281	90.02
90.03	09003	RIVER FOREST	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	201,929	0	351,085	5,462	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I Date/Time Prepared: 11/29/2018 6:55 pm

		Cost Center Description	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,043,265	2,669,838	0	3,223,769	1,884,038	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,782	0	0	179	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	244,699	0	0	0	0	192.00
192.01	19201	NON-EMPLOYEE CHILD CARE CENTER	0	0	0	0	0	192.01
192.02	19202	OUTPATIENT PHARMACY	0	21,708	0	0	5,749	192.02
192.03	19203	WEST TOWN PHO	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	658	193.00
193.01	19301	ADULT DAY CARE	0	14,454	0	13,403	106	193.01
194.00	07950	DISCONTINUED HOME HEALTH AND HOSPICE	0	0	0	0	22	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)	1,287,964	2,710,782	0	3,237,172	1,890,752	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I Date/Time Prepared: 11/29/2018 6:55 pm

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
			15.00	16.00	17.00	19.00	20.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL						12.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY	5,345,305					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	2,618,975				16.00
17.00	01700	SOCIAL SERVICE	0	0	988,483			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
20.00	02000	NURSING SCHOOL	0	0	0		0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0			23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	332,668	460,573	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	72,219	92,235	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	41,153	81,289	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	36,093	132,555	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	83,944	221,831	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	124,550	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	50,357	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	96,445	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	104,219	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	27,470	0	0	0	56.00
56.01	03630	ULTRASOUND	0	52,325	0	0	0	56.01
57.00	05700	CT SCAN	0	236,257	0	0	0	57.00
58.00	05800	MRI	0	64,657	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	60,411	0	0	0	59.00
60.00	06000	LABORATORY	0	346,295	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	73,412	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	98,608	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	11,754	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	5,719	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	92,579	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	9,651	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	43,107	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	69,730	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,366,415	103,540	0	0	0	73.00
73.01	07301	OUTPATIENT PHARMACY	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	LITHOTRIPSY	0	0	0	0	0	76.00
76.01	03951	CARDIAC REHABILITATION	0	10,020	0	0	0	76.01
76.02	03020	GASTROINTESTINAL SERVICES	0	57,182	0	0	0	76.02
76.03	03030	ANGIOCARDIOGRAPHY	0	0	0	0	0	76.03
76.05	03954	INPATIENT RENAL DIALYSIS	0	0	0	0	0	76.05
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	155	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES	0	0	0	0	0	90.01
90.02	04950	WOUND CARE	0	24,080	0	0	0	90.02
90.03	09003	RIVER FOREST	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	290,375	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I Date/Time Prepared: 11/29/2018 6:55 pm

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
			15.00	16.00	17.00	19.00	20.00	
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	4,366,415	2,618,975	988,483	0	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	NON-EMPLOYEE CHILD CARE CENTER	0	0	0	0	0	192.01
192.02	19202	OUTPATIENT PHARMACY	972,172	0	0	0	0	192.02
192.03	19203	WEST TOWN PHO	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT DAY CARE	0	0	0	0	0	193.01
194.00	07950	DISCONTINUED HOME HEALTH AND HOSPICE	6,718	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)	5,345,305	2,618,975	988,483	0	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I Date/Time Prepared: 11/29/2018 6:55 pm

		Cost Center Description	INTERNS & RESIDENTS					
			SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			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		306,770				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)			0			23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	3,068	0	24,305,430	-3,068	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	6,009,309	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	2,336,991	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	4,523,482	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	6,242,939	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	10,285,135	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	925,738	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	153,948	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	3,623,742	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	447,919	0	56.00
56.01	03630	ULTRASOUND	0	0	0	842,311	0	56.01
57.00	05700	CT SCAN	0	0	0	1,029,828	0	57.00
58.00	05800	MRI	0	0	0	565,655	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	1,285,597	0	59.00
60.00	06000	LABORATORY	0	0	0	8,451,583	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	1,847,134	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	4,088,341	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	552,911	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	422,375	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	941,221	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	258,420	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	9,852,784	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	7,704,388	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	5,730,361	0	73.00
73.01	07301	OUTPATIENT PHARMACY	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	LITHOTRIPSY	0	0	0	0	0	76.00
76.01	03951	CARDIAC REHABILITATION	0	0	0	599,430	0	76.01
76.02	03020	GASTROINTESTINAL SERVICES	0	0	0	1,694,344	0	76.02
76.03	03030	ANGIOCARDIOGRAPHY	0	0	0	0	0	76.03
76.05	03954	INPATIENT RENAL DIALYSIS	0	0	0	0	0	76.05
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	155	0	90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES	0	0	0	0	0	90.01
90.02	04950	WOUND CARE	0	0	0	1,424,640	0	90.02
90.03	09003	RIVER FOREST	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	303,702	0	6,838,821	-303,702	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I Date/Time Prepared: 11/29/2018 6:55 pm

		Cost Center Description	INTERNS & RESIDENTS					
			SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			21.00	22.00	23.00	24.00	25.00	
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	306,770	0	112,984,932	-306,770	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	484,196	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	244,699	0	192.00
192.01	19201	NON-EMPLOYEE CHILD CARE CENTER	0	0	0	0	0	192.01
192.02	19202	OUTPATIENT PHARMACY	0	0	0	3,017,356	0	192.02
192.03	19203	WEST TOWN PHO	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	150,438	0	193.00
193.01	19301	ADULT DAY CARE	0	0	0	413,873	0	193.01
194.00	07950	DISCONTINUED HOME HEALTH AND HOSPICE	0	0	0	24,559	0	194.00
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	306,770	0	117,320,053	-306,770	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I | Date/Time Prepared: 11/29/2018 6:55 pm

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
6.00	00600	MAINTENANCE & REPAIRS			6.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
12.00	01200	MAINTENANCE OF PERSONNEL			12.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS			19.00
20.00	02000	NURSING SCHOOL			20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)			23.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	24,302,362		30.00
31.00	03100	INTENSIVE CARE UNIT	6,009,309		31.00
40.00	04000	SUBPROVIDER - IPF	2,336,991		40.00
41.00	04100	SUBPROVIDER - IRF	4,523,482		41.00
43.00	04300	NURSERY	0		43.00
44.00	04400	SKILLED NURSING FACILITY	6,242,939		44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	10,285,135		50.00
51.00	05100	RECOVERY ROOM	925,738		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		52.00
53.00	05300	ANESTHESIOLOGY	153,948		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,623,742		54.00
56.00	05600	RADIOISOTOPE	447,919		56.00
56.01	03630	ULTRASOUND	842,311		56.01
57.00	05700	CT SCAN	1,029,828		57.00
58.00	05800	MRI	565,655		58.00
59.00	05900	CARDIAC CATHETERIZATION	1,285,597		59.00
60.00	06000	LABORATORY	8,451,583		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		62.30
65.00	06500	RESPIRATORY THERAPY	1,847,134		65.00
66.00	06600	PHYSICAL THERAPY	4,088,341		66.00
67.00	06700	OCCUPATIONAL THERAPY	552,911		67.00
68.00	06800	SPEECH PATHOLOGY	422,375		68.00
69.00	06900	ELECTROCARDIOLOGY	941,221		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	258,420		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	9,852,784		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,704,388		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,730,361		73.00
73.01	07301	OUTPATIENT PHARMACY	0		73.01
74.00	07400	RENAL DIALYSIS	0		74.00
76.00	03950	LITHOTRIPSY	0		76.00
76.01	03951	CARDIAC REHABILITATION	599,430		76.01
76.02	03020	GASTROINTESTINAL SERVICES	1,694,344		76.02
76.03	03030	ANGIOCARDIOGRAPHY	0		76.03
76.05	03954	INPATIENT RENAL DIALYSIS	0		76.05
76.97	07697	CARDIAC REHABILITATION	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		76.98
76.99	07699	LITHOTRIPSY	0		76.99
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	155		90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES	0		90.01
90.02	04950	WOUND CARE	1,424,640		90.02
90.03	09003	RIVER FOREST	0		90.03
91.00	09100	EMERGENCY	6,535,119		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
		OTHER REIMBURSABLE COST CENTERS			
99.10	09910	CORF	0		99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0		99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0		99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0		99.40
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	112,678,162		118.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part I Date/Time Prepared: 11/29/2018 6:55 pm

		Cost Center Description	Total		
			26.00		
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	484,196		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	244,699		192.00
192.01	19201	NON-EMPLOYEE CHILD CARE CENTER	0		192.01
192.02	19202	OUTPATIENT PHARMACY	3,017,356		192.02
192.03	19203	WEST TOWN PHO	0		192.03
193.00	19300	NONPAID WORKERS	150,438		193.00
193.01	19301	ADULT DAY CARE	413,873		193.01
194.00	07950	DISCONTINUED HOME HEALTH AND HOSPICE	24,559		194.00
200.00		Cross Foot Adjustments	0		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118 through 201)	117,013,283		202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II Date/Time Prepared: 11/29/2018 6:55 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	123,926	0	123,926	123,926	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	356,050	0	356,050	7,703	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	27,622	0	27,622	1,619	6.00
7.00	00700	OPERATION OF PLANT	0	1,153,586	0	1,153,586	3,215	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	18,989	0	18,989	0	8.00
9.00	00900	HOUSEKEEPING	0	25,082	0	25,082	3,696	9.00
10.00	01000	DIETARY	0	103,604	0	103,604	832	10.00
11.00	01100	CAFETERIA	0	89,710	0	89,710	1,943	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	28,747	0	28,747	4,432	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	111,114	0	111,114	2,299	14.00
15.00	01500	PHARMACY	0	38,074	0	38,074	5,603	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	38,754	0	38,754	3,889	16.00
17.00	01700	SOCIAL SERVICE	0	2,776	0	2,776	1,340	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	0	612,174	5,061,127	5,673,301	20,230	30.00
31.00	03100	INTENSIVE CARE UNIT	0	152,686	0	152,686	7,212	31.00
40.00	04000	SUBPROVIDER - IPF	0	69,639	0	69,639	2,668	40.00
41.00	04100	SUBPROVIDER - IRF	0	154,837	0	154,837	5,058	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	166,816	0	166,816	5,301	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	540,356	0	540,356	7,862	50.00
51.00	05100	RECOVERY ROOM	0	21,057	0	21,057	913	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	8,564	0	8,564	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	139,388	0	139,388	4,442	54.00
56.00	05600	RADIOISOTOPE	0	26,401	0	26,401	464	56.00
56.01	03630	ULTRASOUND	0	26,567	0	26,567	1,261	56.01
57.00	05700	CT SCAN	0	16,907	0	16,907	1,185	57.00
58.00	05800	MRI	0	32,605	0	32,605	478	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	28,636	0	28,636	1,412	59.00
60.00	06000	LABORATORY	0	136,279	0	136,279	5,838	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	15,171	0	15,171	2,744	65.00
66.00	06600	PHYSICAL THERAPY	0	137,195	0	137,195	5,509	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	22,972	0	22,972	715	67.00
68.00	06800	SPEECH PATHOLOGY	0	13,603	0	13,603	580	68.00
69.00	06900	ELECTROCARDIOLOGY	0	28,566	0	28,566	1,031	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	14,477	0	14,477	287	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	OUTPATIENT PHARMACY	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	LITHOTRIPSY	0	0	0	0	0	76.00
76.01	03951	CARDIAC REHABILITATION	0	50,095	0	50,095	518	76.01
76.02	03020	GASTROINTESTINAL SERVICES	0	54,259	0	54,259	1,654	76.02
76.03	03030	ANGIOCARDIOGRAPHY	0	0	0	0	0	76.03
76.05	03954	INPATIENT RENAL DIALYSIS	0	0	0	0	0	76.05
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES	0	0	0	0	0	90.01
90.02	04950	WOUND CARE	0	31,342	0	31,342	668	90.02
90.03	09003	RIVER FOREST	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	158,072	0	158,072	7,856	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II Date/Time Prepared: 11/29/2018 6:55 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	4,776,698	5,061,127	9,837,825	122,457	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	60,797	0	60,797	74	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	NON-EMPLOYEE CHILD CARE CENTER	0	0	0	0	0	192.01
192.02	19202	OUTPATIENT PHARMACY	0	27,567	0	27,567	967	192.02
192.03	19203	WEST TOWN PHO	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	21,404	0	21,404	0	193.00
193.01	19301	ADULT DAY CARE	0	21,931	0	21,931	428	193.01
194.00	07950	DISCONTINUED HOME HEALTH AND HOSPICE	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	4,908,397	5,061,127	9,969,524	123,926	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II | Date/Time Prepared: 11/29/2018 6:55 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	363,753					5.00
6.00	00600	MAINTENANCE & REPAIRS	10,276	39,517				6.00
7.00	00700	OPERATION OF PLANT	21,098	10,358	1,188,257			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	3,028	171	6,949	29,137		8.00
9.00	00900	HOUSEKEEPING	9,782	225	9,178	2,438	50,401	9.00
10.00	01000	DIETARY	2,613	930	37,912	421	1,630	10.00
11.00	01100	CAFETERIA	5,251	806	32,828	0	1,412	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	9,432	258	10,519	0	452	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,042	998	40,660	867	1,748	14.00
15.00	01500	PHARMACY	15,648	342	13,933	188	599	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	7,172	348	14,181	0	610	16.00
17.00	01700	SOCIAL SERVICE	2,910	25	1,016	0	44	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	951	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	58,345	5,497	224,013	4,222	9,634	30.00
31.00	03100	INTENSIVE CARE UNIT	14,041	1,371	55,873	3,213	2,402	31.00
40.00	04000	SUBPROVIDER - IPF	5,088	625	25,483	0	1,096	40.00
41.00	04100	SUBPROVIDER - IRF	9,884	1,390	56,660	906	2,436	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	14,372	1,498	61,043	660	2,625	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	21,679	4,852	197,733	12,417	8,502	50.00
51.00	05100	RECOVERY ROOM	2,269	189	7,705	0	331	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	64	77	3,134	0	135	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,675	1,252	51,007	18	2,193	54.00
56.00	05600	RADIOISOTOPE	933	237	9,661	32	415	56.00
56.01	03630	ULTRASOUND	1,999	239	9,722	249	418	56.01
57.00	05700	CT SCAN	2,160	152	6,187	3	266	57.00
58.00	05800	MRI	1,102	293	11,931	0	513	58.00
59.00	05900	CARDIAC CATHETERIZATION	3,323	257	10,479	75	451	59.00
60.00	06000	LABORATORY	21,891	1,224	49,869	2,923	2,144	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	5,068	136	5,552	0	239	65.00
66.00	06600	PHYSICAL THERAPY	10,157	1,232	50,204	4	2,159	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,336	206	8,406	0	361	67.00
68.00	06800	SPEECH PATHOLOGY	1,069	122	4,978	0	214	68.00
69.00	06900	ELECTROCARDIOLOGY	2,166	257	10,453	16	449	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	557	130	5,298	0	228	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	27,705	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	21,562	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,908	0	0	0	0	73.00
73.01	07301	OUTPATIENT PHARMACY	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	LITHOTRIPSY	0	0	0	0	0	76.00
76.01	03951	CARDIAC REHABILITATION	1,105	450	18,331	0	788	76.01
76.02	03020	GASTROINTESTINAL SERVICES	3,996	487	19,855	295	854	76.02
76.03	03030	ANGIOCARDIOGRAPHY	0	0	0	0	0	76.03
76.05	03954	INPATIENT RENAL DIALYSIS	0	0	0	0	0	76.05
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES	0	0	0	0	0	90.01
90.02	04950	WOUND CARE	3,759	281	11,469	3	493	90.02
90.03	09003	RIVER FOREST	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	15,586	1,419	57,843	89	2,487	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II Date/Time Prepared: 11/29/2018 6:55 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	
			5.00	6.00	7.00	8.00	9.00	
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	356,002	38,334	1,140,065	29,039	48,328	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	703	546	22,247	0	957	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	NON-EMPLOYEE CHILD CARE CENTER	0	0	0	0	0	192.01
192.02	19202	OUTPATIENT PHARMACY	5,901	248	10,088	0	434	192.02
192.03	19203	WEST TOWN PHO	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	178	192	7,832	98	337	193.00
193.01	19301	ADULT DAY CARE	914	197	8,025	0	345	193.01
194.00	07950	DISCONTINUED HOME HEALTH AND HOSPICE	55	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)	363,753	39,517	1,188,257	29,137	50,401	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II Date/Time Prepared: 11/29/2018 6:55 pm

		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	147,942					10.00
11.00	01100	CAFETERIA	74,063	206,013				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	5,766	0	59,606		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	7,203	0	0	168,931	14.00
15.00	01500	PHARMACY	0	8,249	0	0	2,230	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	8,596	0	577	49	16.00
17.00	01700	SOCIAL SERVICE	0	2,916	0	0	5	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	10	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	23,952	41,056	0	22,796	1,055	30.00
31.00	03100	INTENSIVE CARE UNIT	4,277	11,307	0	6,933	493	31.00
40.00	04000	SUBPROVIDER - IPF	3,739	6,227	0	3,120	40	40.00
41.00	04100	SUBPROVIDER - IRF	6,192	10,372	0	5,505	226	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	7,612	12,884	0	6,397	227	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	14,991	0	4,148	5,444	50.00
51.00	05100	RECOVERY ROOM	0	1,360	0	700	27	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	116	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	8,955	0	426	110	54.00
56.00	05600	RADIOISOTOPE	0	645	0	0	19	56.00
56.01	03630	ULTRASOUND	0	1,940	0	0	36	56.01
57.00	05700	CT SCAN	0	1,956	0	0	64	57.00
58.00	05800	MRI	0	755	0	0	33	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,952	0	30	405	59.00
60.00	06000	LABORATORY	0	13,819	0	0	17,261	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	5,415	0	0	425	65.00
66.00	06600	PHYSICAL THERAPY	0	10,915	0	0	21	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,131	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,176	0	0	1	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,303	0	3	28	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	686	0	0	1	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	78,107	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	60,794	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	OUTPATIENT PHARMACY	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	LITHOTRIPSY	0	0	0	0	0	76.00
76.01	03951	CARDIAC REHABILITATION	0	902	0	237	13	76.01
76.02	03020	GASTROINTESTINAL SERVICES	0	2,887	0	1,289	398	76.02
76.03	03030	ANGIOCARDIOGRAPHY	0	0	0	0	0	76.03
76.05	03954	INPATIENT RENAL DIALYSIS	0	0	0	0	0	76.05
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES	0	0	0	0	0	90.01
90.02	04950	WOUND CARE	0	1,192	0	733	204	90.02
90.03	09003	RIVER FOREST	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	15,346	0	6,465	488	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II | Date/Time Prepared: 11/29/2018 6:55 pm

		Cost Center Description	DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	119,835	202,902	0	59,359	168,330	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	363	0	0	16	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	28,107	0	0	0	0	192.00
192.01	19201	NON-EMPLOYEE CHILD CARE CENTER	0	0	0	0	0	192.01
192.02	19202	OUTPATIENT PHARMACY	0	1,650	0	0	514	192.02
192.03	19203	WEST TOWN PHO	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	59	193.00
193.01	19301	ADULT DAY CARE	0	1,098	0	247	10	193.01
194.00	07950	DISCONTINUED HOME HEALTH AND HOSPICE	0	0	0	0	2	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)	147,942	206,013	0	59,606	168,931	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II Date/Time Prepared: 11/29/2018 6:55 pm

		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	84,866					15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	74,176				16.00
17.00	01700	SOCIAL SERVICE	0	0	11,032			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0		19.00
20.00	02000	NURSING SCHOOL	0	0	0		0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0			23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	9,429	5,141			30.00
31.00	03100	INTENSIVE CARE UNIT	0	2,047	1,029			31.00
40.00	04000	SUBPROVIDER - IPF	0	1,166	907			40.00
41.00	04100	SUBPROVIDER - IRF	0	1,023	1,479			41.00
43.00	04300	NURSERY	0	0	0			43.00
44.00	04400	SKILLED NURSING FACILITY	0	2,379	2,476			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	3,530	0			50.00
51.00	05100	RECOVERY ROOM	0	1,427	0			51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0			52.00
53.00	05300	ANESTHESIOLOGY	0	2,734	0			53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,954	0			54.00
56.00	05600	RADIOISOTOPE	0	779	0			56.00
56.01	03630	ULTRASOUND	0	1,483	0			56.01
57.00	05700	CT SCAN	0	6,697	0			57.00
58.00	05800	MRI	0	1,833	0			58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,712	0			59.00
60.00	06000	LABORATORY	0	9,758	0			60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0			62.30
65.00	06500	RESPIRATORY THERAPY	0	2,081	0			65.00
66.00	06600	PHYSICAL THERAPY	0	2,795	0			66.00
67.00	06700	OCCUPATIONAL THERAPY	0	333	0			67.00
68.00	06800	SPEECH PATHOLOGY	0	162	0			68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,624	0			69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	274	0			70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,222	0			71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,976	0			72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	69,324	2,935	0			73.00
73.01	07301	OUTPATIENT PHARMACY	0	0	0			73.01
74.00	07400	RENAL DIALYSIS	0	0	0			74.00
76.00	03950	LITHOTRIPSY	0	0	0			76.00
76.01	03951	CARDIAC REHABILITATION	0	284	0			76.01
76.02	03020	GASTROINTESTINAL SERVICES	0	1,621	0			76.02
76.03	03030	ANGIOCARDIOGRAPHY	0	0	0			76.03
76.05	03954	INPATIENT RENAL DIALYSIS	0	0	0			76.05
76.97	07697	CARDIAC REHABILITATION	0	0	0			76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0			76.98
76.99	07699	LITHOTRIPSY	0	0	0			76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	4	0			90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES	0	0	0			90.01
90.02	04950	WOUND CARE	0	683	0			90.02
90.03	09003	RIVER FOREST	0	0	0			90.03
91.00	09100	EMERGENCY	0	8,231	0			91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0			99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0			99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0			99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0			99.40

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II Date/Time Prepared: 11/29/2018 6:55 pm

		Cost Center Description	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
			15.00	16.00	17.00	19.00	20.00	
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	69,324	74,176	11,032	0	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0			190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0			192.00
192.01	19201	NON-EMPLOYEE CHILD CARE CENTER	0	0	0			192.01
192.02	19202	OUTPATIENT PHARMACY	15,435	0	0			192.02
192.03	19203	WEST TOWN PHO	0	0	0			192.03
193.00	19300	NONPAID WORKERS	0	0	0			193.00
193.01	19301	ADULT DAY CARE	0	0	0			193.01
194.00	07950	DISCONTINUED HOME HEALTH AND HOSPICE	107	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)	84,866	74,176	11,032	0	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II Date/Time Prepared: 11/29/2018 6:55 pm

		Cost Center Description	INTERNS & RESIDENTS: SERVICES-SALARY & FRINGES APPRV	INTERNS & RESIDENTS: SERVICES-OTHER PRGM COSTS APPRV	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			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		961				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)			0			23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS				6,098,671	0	30.00
31.00	03100	INTENSIVE CARE UNIT				262,884	0	31.00
40.00	04000	SUBPROVIDER - IPF				119,798	0	40.00
41.00	04100	SUBPROVIDER - IRF				255,968	0	41.00
43.00	04300	NURSERY				0	0	43.00
44.00	04400	SKILLED NURSING FACILITY				284,290	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM				821,514	0	50.00
51.00	05100	RECOVERY ROOM				35,978	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM				0	0	52.00
53.00	05300	ANESTHESIOLOGY				14,824	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC				219,420	0	54.00
56.00	05600	RADIOISOTOPE				39,586	0	56.00
56.01	03630	ULTRASOUND				43,914	0	56.01
57.00	05700	CT SCAN				35,577	0	57.00
58.00	05800	MRI				49,543	0	58.00
59.00	05900	CARDIAC CATHETERIZATION				48,732	0	59.00
60.00	06000	LABORATORY				261,006	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS				0	0	62.30
65.00	06500	RESPIRATORY THERAPY				36,831	0	65.00
66.00	06600	PHYSICAL THERAPY				220,191	0	66.00
67.00	06700	OCCUPATIONAL THERAPY				35,460	0	67.00
68.00	06800	SPEECH PATHOLOGY				21,905	0	68.00
69.00	06900	ELECTROCARDIOLOGY				47,896	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY				21,938	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT				107,034	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS				84,332	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS				76,167	0	73.00
73.01	07301	OUTPATIENT PHARMACY				0	0	73.01
74.00	07400	RENAL DIALYSIS				0	0	74.00
76.00	03950	LITHOTRIPSY				0	0	76.00
76.01	03951	CARDIAC REHABILITATION				72,723	0	76.01
76.02	03020	GASTROINTESTINAL SERVICES				87,595	0	76.02
76.03	03030	ANGIOCARDIOGRAPHY				0	0	76.03
76.05	03954	INPATIENT RENAL DIALYSIS				0	0	76.05
76.97	07697	CARDIAC REHABILITATION				0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY				0	0	76.98
76.99	07699	LITHOTRIPSY				0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC				4	0	90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES				0	0	90.01
90.02	04950	WOUND CARE				50,827	0	90.02
90.03	09003	RIVER FOREST				0	0	90.03
91.00	09100	EMERGENCY				273,882	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00

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		Cost Center Description	INTERNS & RESIDENTS					
			SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
			21.00	22.00	23.00	24.00	25.00	
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF				0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY				0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY				0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY				0	0	99.40
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	9,728,490	0	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN				85,703	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES				28,107	0	192.00
192.01	19201	NON-EMPLOYEE CHILD CARE CENTER				0	0	192.01
192.02	19202	OUTPATIENT PHARMACY				62,804	0	192.02
192.03	19203	WEST TOWN PHO				0	0	192.03
193.00	19300	NONPAID WORKERS				30,100	0	193.00
193.01	19301	ADULT DAY CARE				33,195	0	193.01
194.00	07950	DISCONTINUED HOME HEALTH AND HOSPICE				164	0	194.00
200.00		Cross Foot Adjustments	0	961	0	961	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	961	0	9,969,524	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II | Date/Time Prepared: 11/29/2018 6:55 pm

		Cost Center Description	Total		
			26.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
6.00	00600	MAINTENANCE & REPAIRS			6.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
12.00	01200	MAINTENANCE OF PERSONNEL			12.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS			19.00
20.00	02000	NURSING SCHOOL			20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV			21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)			23.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	6,098,671		30.00
31.00	03100	INTENSIVE CARE UNIT	262,884		31.00
40.00	04000	SUBPROVIDER - IPF	119,798		40.00
41.00	04100	SUBPROVIDER - IRF	255,968		41.00
43.00	04300	NURSERY	0		43.00
44.00	04400	SKILLED NURSING FACILITY	284,290		44.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	821,514		50.00
51.00	05100	RECOVERY ROOM	35,978		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		52.00
53.00	05300	ANESTHESIOLOGY	14,824		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	219,420		54.00
56.00	05600	RADIOISOTOPE	39,586		56.00
56.01	03630	ULTRASOUND	43,914		56.01
57.00	05700	CT SCAN	35,577		57.00
58.00	05800	MRI	49,543		58.00
59.00	05900	CARDIAC CATHETERIZATION	48,732		59.00
60.00	06000	LABORATORY	261,006		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		62.30
65.00	06500	RESPIRATORY THERAPY	36,831		65.00
66.00	06600	PHYSICAL THERAPY	220,191		66.00
67.00	06700	OCCUPATIONAL THERAPY	35,460		67.00
68.00	06800	SPEECH PATHOLOGY	21,905		68.00
69.00	06900	ELECTROCARDIOLOGY	47,896		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	21,938		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	107,034		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	84,332		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	76,167		73.00
73.01	07301	OUTPATIENT PHARMACY	0		73.01
74.00	07400	RENAL DIALYSIS	0		74.00
76.00	03950	LITHOTRIPSY	0		76.00
76.01	03951	CARDIAC REHABILITATION	72,723		76.01
76.02	03020	GASTROINTESTINAL SERVICES	87,595		76.02
76.03	03030	ANGIOCARDIOGRAPHY	0		76.03
76.05	03954	INPATIENT RENAL DIALYSIS	0		76.05
76.97	07697	CARDIAC REHABILITATION	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		76.98
76.99	07699	LITHOTRIPSY	0		76.99
		OUTPATIENT SERVICE COST CENTERS			
90.00	09000	CLINIC	4		90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES	0		90.01
90.02	04950	WOUND CARE	50,827		90.02
90.03	09003	RIVER FOREST	0		90.03
91.00	09100	EMERGENCY	273,882		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
		OTHER REIMBURSABLE COST CENTERS			
99.10	09910	CORF	0		99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0		99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0		99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0		99.40
		SPECIAL PURPOSE COST CENTERS			
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	9,728,490		118.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B Part II Date/Time Prepared: 11/29/2018 6:55 pm

		Cost Center Description	Total		
			26.00		
		NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	85,703		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	28,107		192.00
192.01	19201	NON-EMPLOYEE CHILD CARE CENTER	0		192.01
192.02	19202	OUTPATIENT PHARMACY	62,804		192.02
192.03	19203	WEST TOWN PHO	0		192.03
193.00	19300	NONPAID WORKERS	30,100		193.00
193.01	19301	ADULT DAY CARE	33,195		193.01
194.00	07950	DISCONTINUED HOME HEALTH AND HOSPICE	164		194.00
200.00		Cross Foot Adjustments	961		200.00
201.00		Negative Cost Centers	0		201.00
202.00		TOTAL (sum lines 118 through 201)	9,969,524		202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 11/29/2018 6:55 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP ((DOLLAR VALUE))	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	353,617					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		19				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	8,928	0	47,945,162			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	25,651	0	2,979,712	-19,850,818	97,469,235	5.00
6.00	00600	MAINTENANCE & REPAIRS	1,990	0	626,466	0	2,753,532	6.00
7.00	00700	OPERATION OF PLANT	83,108	0	1,243,890	0	5,653,363	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,368	0	0	0	811,254	8.00
9.00	00900	HOUSEKEEPING	1,807	0	1,429,959	0	2,621,039	9.00
10.00	01000	DIETARY	7,464	0	321,729	0	700,167	10.00
11.00	01100	CAFETERIA	6,463	0	751,759	0	1,406,936	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	2,071	0	1,714,349	0	2,527,228	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	8,005	0	889,200	0	1,083,135	14.00
15.00	01500	PHARMACY	2,743	0	2,167,326	0	4,193,050	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,792	0	1,504,295	0	1,921,690	16.00
17.00	01700	SOCIAL SERVICE	200	0	518,472	0	779,736	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	254,773	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	44,103	19	7,830,852	0	15,634,143	30.00
31.00	03100	INTENSIVE CARE UNIT	11,000	0	2,790,018	0	3,762,318	31.00
40.00	04000	SUBPROVIDER - IPF	5,017	0	1,031,977	0	1,363,312	40.00
41.00	04100	SUBPROVIDER - IRF	11,155	0	1,956,778	0	2,648,373	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	12,018	0	2,050,560	0	3,850,960	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	38,929	0	3,041,448	0	5,808,840	50.00
51.00	05100	RECOVERY ROOM	1,517	0	353,354	0	607,917	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	617	0	0	0	17,150	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,042	0	1,718,478	0	2,324,480	54.00
56.00	05600	RADIOISOTOPE	1,902	0	179,528	0	250,041	56.00
56.01	03630	ULTRASOUND	1,914	0	487,854	0	535,771	56.01
57.00	05700	CT SCAN	1,218	0	458,433	0	578,908	57.00
58.00	05800	MRI	2,349	0	185,077	0	295,174	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,063	0	546,057	0	890,414	59.00
60.00	06000	LABORATORY	9,818	0	2,258,476	0	5,865,813	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,093	0	1,061,504	0	1,358,117	65.00
66.00	06600	PHYSICAL THERAPY	9,884	0	2,131,096	0	2,721,715	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,655	0	276,741	0	357,972	67.00
68.00	06800	SPEECH PATHOLOGY	980	0	224,241	0	286,357	68.00
69.00	06900	ELECTROCARDIOLOGY	2,058	0	398,852	0	580,473	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,043	0	111,193	0	149,218	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	7,423,543	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	5,777,563	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,047,143	73.00
73.01	07301	OUTPATIENT PHARMACY	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	LITHOTRIPSY	0	0	0	0	0	76.00
76.01	03951	CARDIAC REHABILITATION	3,609	0	200,205	0	296,188	76.01
76.02	03020	GASTROINTESTINAL SERVICES	3,909	0	639,874	0	1,070,815	76.02
76.03	03030	ANGIOCARDIOGRAPHY	0	0	0	0	0	76.03
76.05	03954	INPATIENT RENAL DIALYSIS	0	0	0	0	0	76.05
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES	0	0	0	0	0	90.01
90.02	04950	WOUND CARE	2,258	0	258,346	0	1,007,361	90.02
90.03	09003	RIVER FOREST	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	11,388	0	3,039,078	0	4,176,181	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 11/29/2018 6:55 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP ((DOLLAR VALUE))	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
			1.00	2.00	4.00	5A	5.00	
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	344,129	19	47,377,177	-19,850,818	95,392,163	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,380	0	28,514	0	188,401	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	NON-EMPLOYEE CHILD CARE CENTER	0	0	0	0	0	192.01
192.02	19202	OUTPATIENT PHARMACY	1,986	0	374,052	0	1,581,219	192.02
192.03	19203	WEST TOWN PHO	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	1,542	0	0	0	47,697	193.00
193.01	19301	ADULT DAY CARE	1,580	0	165,419	0	244,951	193.01
194.00	07950	DISCONTINUED HOME HEALTH AND HOSPICE	0	0	0	0	14,804	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)	4,908,397	5,061,127	7,970,176		19,850,818	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	13.880546	266,375.105263	0.166235		0.203662	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			123,926		363,753	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.002585		0.003732	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 11/29/2018 6:55 pm

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE ((POUNDS OF LAUNDRY))	HOUSEKEEPING (SQUARE FEET)	DIETARY ((MEALS SERVED))	
			6.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS	317,048					6.00
7.00	00700	OPERATION OF PLANT	83,108	233,940				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,368	1,368	885,844			8.00
9.00	00900	HOUSEKEEPING	1,807	1,807	74,127	230,765		9.00
10.00	01000	DIETARY	7,464	7,464	12,807	7,464	381,585	10.00
11.00	01100	CAFETERIA	6,463	6,463	0	6,463	191,028	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	2,071	2,071	0	2,071	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	8,005	8,005	26,368	8,005	0	14.00
15.00	01500	PHARMACY	2,743	2,743	5,720	2,743	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,792	2,792	0	2,792	0	16.00
17.00	01700	SOCIAL SERVICE	200	200	0	200	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	44,103	44,103	128,361	44,103	61,778	30.00
31.00	03100	INTENSIVE CARE UNIT	11,000	11,000	97,672	11,000	11,032	31.00
40.00	04000	SUBPROVIDER - IPF	5,017	5,017	0	5,017	9,644	40.00
41.00	04100	SUBPROVIDER - IRF	11,155	11,155	27,552	11,155	15,972	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	12,018	12,018	20,061	12,018	19,634	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	38,929	38,929	377,531	38,929	0	50.00
51.00	05100	RECOVERY ROOM	1,517	1,517	0	1,517	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	617	617	0	617	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,042	10,042	534	10,042	0	54.00
56.00	05600	RADIOISOTOPE	1,902	1,902	984	1,902	0	56.00
56.01	03630	ULTRASOUND	1,914	1,914	7,567	1,914	0	56.01
57.00	05700	CT SCAN	1,218	1,218	81	1,218	0	57.00
58.00	05800	MRI	2,349	2,349	0	2,349	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,063	2,063	2,271	2,063	0	59.00
60.00	06000	LABORATORY	9,818	9,818	88,868	9,818	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,093	1,093	0	1,093	0	65.00
66.00	06600	PHYSICAL THERAPY	9,884	9,884	110	9,884	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,655	1,655	0	1,655	0	67.00
68.00	06800	SPEECH PATHOLOGY	980	980	0	980	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,058	2,058	491	2,058	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,043	1,043	0	1,043	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	OUTPATIENT PHARMACY	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	LITHOTRIPSY	0	0	0	0	0	76.00
76.01	03951	CARDIAC REHABILITATION	3,609	3,609	0	3,609	0	76.01
76.02	03020	GASTROINTESTINAL SERVICES	3,909	3,909	8,964	3,909	0	76.02
76.03	03030	ANGIOCARDIOGRAPHY	0	0	0	0	0	76.03
76.05	03954	INPATIENT RENAL DIALYSIS	0	0	0	0	0	76.05
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES	0	0	0	0	0	90.01
90.02	04950	WOUND CARE	2,258	2,258	99	2,258	0	90.02
90.03	09003	RIVER FOREST	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	11,388	11,388	2,693	11,388	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 11/29/2018 6:55 pm

		Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE ((POUNDS OF LAUNDRY))	HOUSEKEEPING (SQUARE FEET)	DIETARY ((MEALS SERVED))	
			6.00	7.00	8.00	9.00	10.00	
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	307,560	224,452	882,861	221,277	309,088	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,380	4,380	0	4,380	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	72,497	192.00
192.01	19201	NON-EMPLOYEE CHILD CARE CENTER	0	0	0	0	0	192.01
192.02	19202	OUTPATIENT PHARMACY	1,986	1,986	0	1,986	0	192.02
192.03	19203	WEST TOWN PHO	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	1,542	1,542	2,983	1,542	0	193.00
193.01	19301	ADULT DAY CARE	1,580	1,580	0	1,580	0	193.01
194.00	07950	DISCONTINUED HOME HEALTH AND HOSPICE	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,314,322	7,673,523	1,035,649	3,319,670	1,287,964	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	10.453692	32.801244	1.169110	14.385500	3.375300	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	39,517	1,188,257	29,137	50,401	147,942	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.124640	5.079324	0.032892	0.218408	0.387704	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 11/29/2018 6:55 pm

		Cost Center Description	CAFETERIA ((FTES SERVED))	MAINTENANCE OF PERSONNEL ((FTES SERVED))	NURSING ADMINISTRATION ((FTES SERVED))	CENTRAL SERVICES & SUPPLY ((COSTED REQUIS))	PHARMACY ((COSTED REQUIS))	
			11.00	12.00	13.00	14.00	15.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	50,449					11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300	NURSING ADMINISTRATION	1,412	0	23,669			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,764	0	0	16,055,138		14.00
15.00	01500	PHARMACY	2,020	0	0	211,905	1,281,898	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,105	0	229	4,668	0	16.00
17.00	01700	SOCIAL SERVICE	714	0	0	430	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	927	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,053	0	9,053	100,222	0	30.00
31.00	03100	INTENSIVE CARE UNIT	2,769	0	2,753	46,828	0	31.00
40.00	04000	SUBPROVIDER - IPF	1,525	0	1,239	3,824	0	40.00
41.00	04100	SUBPROVIDER - IRF	2,540	0	2,186	21,480	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	3,155	0	2,540	21,595	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	3,671	0	1,647	517,397	0	50.00
51.00	05100	RECOVERY ROOM	333	0	278	2,535	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	11,004	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,193	0	169	10,484	0	54.00
56.00	05600	RADIOISOTOPE	158	0	0	1,798	0	56.00
56.01	03630	ULTRASOUND	475	0	0	3,439	0	56.01
57.00	05700	CT SCAN	479	0	0	6,119	0	57.00
58.00	05800	MRI	185	0	0	3,131	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	478	0	12	38,528	0	59.00
60.00	06000	LABORATORY	3,384	0	0	1,640,445	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,326	0	0	40,392	0	65.00
66.00	06600	PHYSICAL THERAPY	2,673	0	0	1,981	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	277	0	0	5	0	67.00
68.00	06800	SPEECH PATHOLOGY	288	0	0	138	0	68.00
69.00	06900	ELECTROCARDIOLOGY	564	0	1	2,626	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	168	0	0	128	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	7,423,543	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	5,777,775	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	1,047,143	73.00
73.01	07301	OUTPATIENT PHARMACY	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	LITHOTRIPSY	0	0	0	0	0	76.00
76.01	03951	CARDIAC REHABILITATION	221	0	94	1,228	0	76.01
76.02	03020	GASTROINTESTINAL SERVICES	707	0	512	37,809	0	76.02
76.03	03030	ANGIOCARDIOGRAPHY	0	0	0	0	0	76.03
76.05	03954	INPATIENT RENAL DIALYSIS	0	0	0	0	0	76.05
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES	0	0	0	0	0	90.01
90.02	04950	WOUND CARE	292	0	291	19,373	0	90.02
90.03	09003	RIVER FOREST	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	3,758	0	2,567	46,376	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 11/29/2018 6:55 pm

		Cost Center Description	CAFETERIA ((FTES SERVED))	MAINTENANCE OF PERSONNEL ((FTES SERVED))	NURSING ADMINISTRATION ((FTES SERVED))	CENTRAL SERVICES & SUPPLY ((COSTED REQUIS))	PHARMACY ((COSTED REQUIS))	
			11.00	12.00	13.00	14.00	15.00	
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	49,687	0	23,571	15,998,133	1,047,143	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	89	0	0	1,516	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	NON-EMPLOYEE CHILD CARE CENTER	0	0	0	0	0	192.01
192.02	19202	OUTPATIENT PHARMACY	404	0	0	48,814	233,144	192.02
192.03	19203	WEST TOWN PHO	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	5,586	0	193.00
193.01	19301	ADULT DAY CARE	269	0	98	904	0	193.01
194.00	07950	DISCONTINUED HOME HEALTH AND HOSPICE	0	0	0	185	1,611	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,710,782	0	3,237,172	1,890,752	5,345,305	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	53.733117	0.000000	136.768431	0.117766	4.169836	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	206,013	0	59,606	168,931	84,866	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	4.083589	0.000000	2.518315	0.010522	0.066203	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 11/29/2018 6:55 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALARY & 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	562,324,535					16.00
17.00	01700	SOCIAL SERVICE	0	41,089				17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
20.00	02000	NURSING SCHOOL	0	0		0		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0			100	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0				22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0				23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	71,433,982	19,145	0	0	1	30.00
31.00	03100	INTENSIVE CARE UNIT	15,507,614	3,834	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	8,836,744	3,379	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	7,750,164	5,510	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	18,025,241	9,221	0	0	0	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	26,744,596	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	10,813,082	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	20,709,706	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	22,378,903	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	5,898,551	0	0	0	0	56.00
56.01	03630	ULTRASOUND	11,235,843	0	0	0	0	56.01
57.00	05700	CT SCAN	50,731,515	0	0	0	0	57.00
58.00	05800	MRI	13,883,849	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	12,972,101	0	0	0	0	59.00
60.00	06000	LABORATORY	74,311,318	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	15,763,766	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	21,174,044	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,523,957	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,228,083	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	19,879,490	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	2,072,383	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	9,256,284	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	14,973,158	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	22,233,285	0	0	0	0	73.00
73.01	07301	OUTPATIENT PHARMACY	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	LITHOTRIPSY	0	0	0	0	0	76.00
76.01	03951	CARDIAC REHABILITATION	2,151,701	0	0	0	0	76.01
76.02	03020	GASTROINTESTINAL SERVICES	12,278,814	0	0	0	0	76.02
76.03	03030	ANGIOCARDIOGRAPHY	0	0	0	0	0	76.03
76.05	03954	INPATIENT RENAL DIALYSIS	0	0	0	0	0	76.05
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	33,183	0	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES	0	0	0	0	0	90.01
90.02	04950	WOUND CARE	5,170,732	0	0	0	0	90.02
90.03	09003	RIVER FOREST	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	62,352,446	0	0	0	99	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 11/29/2018 6:55 pm

		Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS SERVICES-SALARY & FRINGES APPRV ((ASSIGNED TIME))	
			16.00	17.00	19.00	20.00	21.00	
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
		SPECIAL PURPOSE COST CENTERS						
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	562,324,535	41,089	0	0	100	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	NON-EMPLOYEE CHILD CARE CENTER	0	0	0	0	0	192.01
192.02	19202	OUTPATIENT PHARMACY	0	0	0	0	0	192.02
192.03	19203	WEST TOWN PHO	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301	ADULT DAY CARE	0	0	0	0	0	193.01
194.00	07950	DISCONTINUED HOME HEALTH AND HOSPICE	0	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,618,975	988,483	0	0	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.004657	24.057120	0.000000	0.000000	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	74,176	11,032	0	0	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000132	0.268490	0.000000	0.000000	0.000000	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)				0		206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)				0.000000		207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 11/29/2018 6:55 pm

		Cost Center Description	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV ((ASSIGNED TIME))	PARAMED ED PRGM (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	100			22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)		0		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	1	0		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
40.00	04000	SUBPROVIDER - IPF	0	0		40.00
41.00	04100	SUBPROVIDER - IRF	0	0		41.00
43.00	04300	NURSERY	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0		44.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
56.01	03630	ULTRASOUND	0	0		56.01
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
73.01	07301	OUTPATIENT PHARMACY	0	0		73.01
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	LITHOTRIPSY	0	0		76.00
76.01	03951	CARDIAC REHABILITATION	0	0		76.01
76.02	03020	GASTROINTESTINAL SERVICES	0	0		76.02
76.03	03030	ANGIOCARDIOGRAPHY	0	0		76.03
76.05	03954	INPATIENT RENAL DIALYSIS	0	0		76.05
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0		76.99
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES	0	0		90.01
90.02	04950	WOUND CARE	0	0		90.02
90.03	09003	RIVER FOREST	0	0		90.03
91.00	09100	EMERGENCY	99	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet B-1 | Date/Time Prepared: 11/29/2018 6:55 pm

		Cost Center Description	INTERNS & RESIDENTS SERVICES-OTHER PRGM COSTS APPRV ((ASSIGNED TIME))	PARAMED ED PRGM (ASSIGNED TIME)		
			22.00	23.00		
		OTHER REIMBURSABLE COST CENTERS				
99.10	09910	CORF	0	0		99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0		99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0		99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0		99.40
		SPECIAL PURPOSE COST CENTERS				
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	100	0		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
192.01	19201	NON-EMPLOYEE CHILD CARE CENTER	0	0		192.01
192.02	19202	OUTPATIENT PHARMACY	0	0		192.02
192.03	19203	WEST TOWN PHO	0	0		192.03
193.00	19300	NONPAID WORKERS	0	0		193.00
193.01	19301	ADULT DAY CARE	0	0		193.01
194.00	07950	DISCONTINUED HOME HEALTH AND HOSPICE	0	0		194.00
200.00		Cross Foot Adjustments				200.00
201.00		Negative Cost Centers				201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	306,770	0		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	3,067.700000	0.000000		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	961	0		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	9.610000	0.000000		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)		0		206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)		0.000000		207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 11/29/2018 6:55 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	24,302,362		24,302,362	0	24,302,362	30.00
31.00	03100	INTENSIVE CARE UNIT	6,009,309		6,009,309	0	6,009,309	31.00
40.00	04000	SUBPROVIDER - IPF	2,336,991		2,336,991	0	2,336,991	40.00
41.00	04100	SUBPROVIDER - IRF	4,523,482		4,523,482	0	4,523,482	41.00
43.00	04300	NURSERY	0		0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	6,242,939		6,242,939	0	6,242,939	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,285,135		10,285,135	0	10,285,135	50.00
51.00	05100	RECOVERY ROOM	925,738		925,738	0	925,738	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	153,948		153,948	0	153,948	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,623,742		3,623,742	0	3,623,742	54.00
56.00	05600	RADIOISOTOPE	447,919		447,919	0	447,919	56.00
56.01	03630	ULTRASOUND	842,311		842,311	0	842,311	56.01
57.00	05700	CT SCAN	1,029,828		1,029,828	0	1,029,828	57.00
58.00	05800	MRI	565,655		565,655	0	565,655	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,285,597		1,285,597	0	1,285,597	59.00
60.00	06000	LABORATORY	8,451,583		8,451,583	0	8,451,583	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,847,134	0	1,847,134	0	1,847,134	65.00
66.00	06600	PHYSICAL THERAPY	4,088,341	0	4,088,341	0	4,088,341	66.00
67.00	06700	OCCUPATIONAL THERAPY	552,911	0	552,911	0	552,911	67.00
68.00	06800	SPEECH PATHOLOGY	422,375	0	422,375	0	422,375	68.00
69.00	06900	ELECTROCARDIOLOGY	941,221		941,221	0	941,221	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	258,420		258,420	0	258,420	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	9,852,784		9,852,784	0	9,852,784	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,704,388		7,704,388	0	7,704,388	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,730,361		5,730,361	0	5,730,361	73.00
73.01	07301	OUTPATIENT PHARMACY	0		0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0		0	0	0	74.00
76.00	03950	LITHOTRIPSY	0		0	0	0	76.00
76.01	03951	CARDIAC REHABILITATION	599,430		599,430	0	599,430	76.01
76.02	03020	GASTROINTESTINAL SERVICES	1,694,344		1,694,344	0	1,694,344	76.02
76.03	03030	ANGIOCARDIOGRAPHY	0		0	0	0	76.03
76.05	03954	INPATIENT RENAL DIALYSIS	0		0	0	0	76.05
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98
76.99	07699	LITHOTRIPSY	0		0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	155		155	0	155	90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES	0		0	0	0	90.01
90.02	04950	WOUND CARE	1,424,640		1,424,640	0	1,424,640	90.02
90.03	09003	RIVER FOREST	0		0	0	0	90.03
91.00	09100	EMERGENCY	6,535,119		6,535,119	0	6,535,119	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,881,142		2,881,142		2,881,142	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0		0		0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0		0		0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0		0		0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0		0		0	99.40
200.00		Subtotal (see instructions)	115,559,304	0	115,559,304	0	115,559,304	200.00
201.00		Less Observation Beds	2,881,142		2,881,142		2,881,142	201.00
202.00		Total (see instructions)	112,678,162	0	112,678,162	0	112,678,162	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I | Date/Time Prepared: 11/29/2018 6:55 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	61,119,032		61,119,032			30.00
31.00	03100	INTENSIVE CARE UNIT	15,507,614		15,507,614			31.00
40.00	04000	SUBPROVIDER - IPF	8,836,744		8,836,744			40.00
41.00	04100	SUBPROVIDER - IRF	7,750,164		7,750,164			41.00
43.00	04300	NURSERY	0		0			43.00
44.00	04400	SKILLED NURSING FACILITY	18,025,241		18,025,241			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,603,458	16,141,138	26,744,596	0.384569	0.000000	50.00
51.00	05100	RECOVERY ROOM	4,416,061	6,397,021	10,813,082	0.085613	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	8,394,608	12,315,098	20,709,706	0.007434	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,242,892	17,136,011	22,378,903	0.161927	0.000000	54.00
56.00	05600	RADIOISOTOPE	1,670,747	4,227,804	5,898,551	0.075937	0.000000	56.00
56.01	03630	ULTRASOUND	2,916,006	8,319,837	11,235,843	0.074966	0.000000	56.01
57.00	05700	CT SCAN	14,173,530	36,557,985	50,731,515	0.020300	0.000000	57.00
58.00	05800	MRI	2,523,198	11,360,651	13,883,849	0.040742	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	7,263,509	5,708,592	12,972,101	0.099105	0.000000	59.00
60.00	06000	LABORATORY	33,138,333	41,172,985	74,311,318	0.113732	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	14,590,406	1,173,360	15,763,766	0.117176	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	15,420,181	5,753,863	21,174,044	0.193083	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,697,338	826,619	2,523,957	0.219065	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	562,620	665,463	1,228,083	0.343930	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	8,835,981	11,043,509	19,879,490	0.047346	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	287,154	1,785,229	2,072,383	0.124697	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,244,655	4,011,629	9,256,284	1.064443	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,929,455	4,043,703	14,973,158	0.514547	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,107,310	7,125,975	22,233,285	0.257738	0.000000	73.00
73.01	07301	OUTPATIENT PHARMACY	0	0	0	0.000000	0.000000	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
76.00	03950	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.00
76.01	03951	CARDIAC REHABILITATION	1,308	2,150,393	2,151,701	0.278584	0.000000	76.01
76.02	03020	GASTROINTESTINAL SERVICES	2,313,338	9,965,476	12,278,814	0.137989	0.000000	76.02
76.03	03030	ANGIOCARDIOGRAPHY	0	0	0	0.000000	0.000000	76.03
76.05	03954	INPATIENT RENAL DIALYSIS	0	0	0	0.000000	0.000000	76.05
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	33,183	33,183	0.004671	0.000000	90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES	0	0	0	0.000000	0.000000	90.01
90.02	04950	WOUND CARE	9,009	5,161,723	5,170,732	0.275520	0.000000	90.02
90.03	09003	RIVER FOREST	0	0	0	0.000000	0.000000	90.03
91.00	09100	EMERGENCY	16,563,072	45,789,374	62,352,446	0.104809	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3,079,001	7,235,949	10,314,950	0.279317	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0			99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0			99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0			99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0			99.40
200.00		Subtotal (see instructions)	296,221,965	266,102,570	562,324,535			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	296,221,965	266,102,570	562,324,535			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 11/29/2018 6:55 pm

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio	
			11.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
40.00	04000	SUBPROVIDER - IPF		40.00
41.00	04100	SUBPROVIDER - IRF		41.00
43.00	04300	NURSERY		43.00
44.00	04400	SKILLED NURSING FACILITY		44.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0.384569	50.00
51.00	05100	RECOVERY ROOM	0.085613	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0.007434	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.161927	54.00
56.00	05600	RADIOISOTOPE	0.075937	56.00
56.01	03630	ULTRASOUND	0.074966	56.01
57.00	05700	CT SCAN	0.020300	57.00
58.00	05800	MRI	0.040742	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.099105	59.00
60.00	06000	LABORATORY	0.113732	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	0.117176	65.00
66.00	06600	PHYSICAL THERAPY	0.193083	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.219065	67.00
68.00	06800	SPEECH PATHOLOGY	0.343930	68.00
69.00	06900	ELECTROCARDIOLOGY	0.047346	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.124697	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.064443	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.514547	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.257738	73.00
73.01	07301	OUTPATIENT PHARMACY	0.000000	73.01
74.00	07400	RENAL DIALYSIS	0.000000	74.00
76.00	03950	LITHOTRIPSY	0.000000	76.00
76.01	03951	CARDIAC REHABILITATION	0.278584	76.01
76.02	03020	GASTROINTESTINAL SERVICES	0.137989	76.02
76.03	03030	ANGIOCARDIOGRAPHY	0.000000	76.03
76.05	03954	INPATIENT RENAL DIALYSIS	0.000000	76.05
76.97	07697	CARDIAC REHABILITATION	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	76.98
76.99	07699	LITHOTRIPSY	0.000000	76.99
		OUTPATIENT SERVICE COST CENTERS		
90.00	09000	CLINIC	0.004671	90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES	0.000000	90.01
90.02	04950	WOUND CARE	0.275520	90.02
90.03	09003	RIVER FOREST	0.000000	90.03
91.00	09100	EMERGENCY	0.104809	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.279317	92.00
		OTHER REIMBURSABLE COST CENTERS		
99.10	09910	CORF		99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY		99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY		99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY		99.40
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 11/29/2018 6:55 pm

Title XIX | Hospital | Cost

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	24,302,362		24,302,362	0	24,302,362	30.00
31.00	03100	INTENSIVE CARE UNIT	6,009,309		6,009,309	0	6,009,309	31.00
40.00	04000	SUBPROVIDER - IPF	2,336,991		2,336,991	0	2,336,991	40.00
41.00	04100	SUBPROVIDER - IRF	4,523,482		4,523,482	0	4,523,482	41.00
43.00	04300	NURSERY	0		0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	6,242,939		6,242,939	0	6,242,939	44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,285,135		10,285,135	0	10,285,135	50.00
51.00	05100	RECOVERY ROOM	925,738		925,738	0	925,738	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	153,948		153,948	0	153,948	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,623,742		3,623,742	0	3,623,742	54.00
56.00	05600	RADIOISOTOPE	447,919		447,919	0	447,919	56.00
56.01	03630	ULTRASOUND	842,311		842,311	0	842,311	56.01
57.00	05700	CT SCAN	1,029,828		1,029,828	0	1,029,828	57.00
58.00	05800	MRI	565,655		565,655	0	565,655	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,285,597		1,285,597	0	1,285,597	59.00
60.00	06000	LABORATORY	8,451,583		8,451,583	0	8,451,583	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,847,134	0	1,847,134	0	1,847,134	65.00
66.00	06600	PHYSICAL THERAPY	4,088,341	0	4,088,341	0	4,088,341	66.00
67.00	06700	OCCUPATIONAL THERAPY	552,911	0	552,911	0	552,911	67.00
68.00	06800	SPEECH PATHOLOGY	422,375	0	422,375	0	422,375	68.00
69.00	06900	ELECTROCARDIOLOGY	941,221		941,221	0	941,221	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	258,420		258,420	0	258,420	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	9,852,784		9,852,784	0	9,852,784	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	7,704,388		7,704,388	0	7,704,388	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	5,730,361		5,730,361	0	5,730,361	73.00
73.01	07301	OUTPATIENT PHARMACY	0		0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0		0	0	0	74.00
76.00	03950	LITHOTRIPSY	0		0	0	0	76.00
76.01	03951	CARDIAC REHABILITATION	599,430		599,430	0	599,430	76.01
76.02	03020	GASTROINTESTINAL SERVICES	1,694,344		1,694,344	0	1,694,344	76.02
76.03	03030	ANGIOCARDIOGRAPHY	0		0	0	0	76.03
76.05	03954	INPATIENT RENAL DIALYSIS	0		0	0	0	76.05
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98
76.99	07699	LITHOTRIPSY	0		0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	155		155	0	155	90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES	0		0	0	0	90.01
90.02	04950	WOUND CARE	1,424,640		1,424,640	0	1,424,640	90.02
90.03	09003	RIVER FOREST	0		0	0	0	90.03
91.00	09100	EMERGENCY	6,535,119		6,535,119	0	6,535,119	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,881,142		2,881,142		2,881,142	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0		0		0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0		0		0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0		0		0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0		0		0	99.40
200.00		Subtotal (see instructions)	115,559,304	0	115,559,304	0	115,559,304	200.00
201.00		Less Observation Beds	2,881,142		2,881,142		2,881,142	201.00
202.00		Total (see instructions)	112,678,162	0	112,678,162	0	112,678,162	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 11/29/2018 6:55 pm

Title XIX | Hospital | Cost

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	61,119,032		61,119,032			30.00
31.00	03100	INTENSIVE CARE UNIT	15,507,614		15,507,614			31.00
40.00	04000	SUBPROVIDER - IPF	8,836,744		8,836,744			40.00
41.00	04100	SUBPROVIDER - IRF	7,750,164		7,750,164			41.00
43.00	04300	NURSERY	0		0			43.00
44.00	04400	SKILLED NURSING FACILITY	18,025,241		18,025,241			44.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	10,603,458	16,141,138	26,744,596	0.384569	0.000000	50.00
51.00	05100	RECOVERY ROOM	4,416,061	6,397,021	10,813,082	0.085613	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	8,394,608	12,315,098	20,709,706	0.007434	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,242,892	17,136,011	22,378,903	0.161927	0.000000	54.00
56.00	05600	RADIOISOTOPE	1,670,747	4,227,804	5,898,551	0.075937	0.000000	56.00
56.01	03630	ULTRASOUND	2,916,006	8,319,837	11,235,843	0.074966	0.000000	56.01
57.00	05700	CT SCAN	14,173,530	36,557,985	50,731,515	0.020300	0.000000	57.00
58.00	05800	MRI	2,523,198	11,360,651	13,883,849	0.040742	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	7,263,509	5,708,592	12,972,101	0.099105	0.000000	59.00
60.00	06000	LABORATORY	33,138,333	41,172,985	74,311,318	0.113732	0.000000	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	14,590,406	1,173,360	15,763,766	0.117176	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	15,420,181	5,753,863	21,174,044	0.193083	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,697,338	826,619	2,523,957	0.219065	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	562,620	665,463	1,228,083	0.343930	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	8,835,981	11,043,509	19,879,490	0.047346	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	287,154	1,785,229	2,072,383	0.124697	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,244,655	4,011,629	9,256,284	1.064443	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	10,929,455	4,043,703	14,973,158	0.514547	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	15,107,310	7,125,975	22,233,285	0.257738	0.000000	73.00
73.01	07301	OUTPATIENT PHARMACY	0	0	0	0.000000	0.000000	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	0.000000	74.00
76.00	03950	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.00
76.01	03951	CARDIAC REHABILITATION	1,308	2,150,393	2,151,701	0.278584	0.000000	76.01
76.02	03020	GASTROINTESTINAL SERVICES	2,313,338	9,965,476	12,278,814	0.137989	0.000000	76.02
76.03	03030	ANGIOCARDIOGRAPHY	0	0	0	0.000000	0.000000	76.03
76.05	03954	INPATIENT RENAL DIALYSIS	0	0	0	0.000000	0.000000	76.05
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0.000000	0.000000	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	33,183	33,183	0.004671	0.000000	90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES	0	0	0	0.000000	0.000000	90.01
90.02	04950	WOUND CARE	9,009	5,161,723	5,170,732	0.275520	0.000000	90.02
90.03	09003	RIVER FOREST	0	0	0	0.000000	0.000000	90.03
91.00	09100	EMERGENCY	16,563,072	45,789,374	62,352,446	0.104809	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3,079,001	7,235,949	10,314,950	0.279317	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
99.10	09910	CORF	0	0	0			99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0			99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0			99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0			99.40
200.00		Subtotal (see instructions)	296,221,965	266,102,570	562,324,535			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	296,221,965	266,102,570	562,324,535			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet C Part I Date/Time Prepared: 11/29/2018 6:55 pm

Title XIX | Hospital | Cost

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

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part I | Date/Time Prepared: 11/29/2018 6:55 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	6,098,671	0	6,098,671	21,720	280.79	30.00
31.00	INTENSIVE CARE UNIT	262,884		262,884	3,834	68.57	31.00
40.00	SUBPROVIDER - IPF	119,798	0	119,798	3,379	35.45	40.00
41.00	SUBPROVIDER - IRF	255,968	0	255,968	5,510	46.46	41.00
43.00	NURSERY	0		0	0	0.00	43.00
44.00	SKILLED NURSING FACILITY	284,290		284,290	9,221	30.83	44.00
200.00	Total (lines 30 through 199)	7,021,611		7,021,611	43,664		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	9,685	2,719,451	30.00
31.00	INTENSIVE CARE UNIT	1,660	113,826	31.00
40.00	SUBPROVIDER - IPF	3,078	109,115	40.00
41.00	SUBPROVIDER - IRF	2,986	138,730	41.00
43.00	NURSERY	0	0	43.00
44.00	SKILLED NURSING FACILITY	6,334	195,277	44.00
200.00	Total (lines 30 through 199)	23,743	3,276,399	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part II Date/Time Prepared: 11/29/2018 6:55 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	821,514	26,744,596	0.030717	4,059,194	124,686	50.00
51.00	05100	RECOVERY ROOM	35,978	10,813,082	0.003327	1,666,226	5,544	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	14,824	20,709,706	0.000716	3,271,174	2,342	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	219,420	22,378,903	0.009805	2,451,935	24,041	54.00
56.00	05600	RADIOISOTOPE	39,586	5,898,551	0.006711	730,205	4,900	56.00
56.01	03630	ULTRASOUND	43,914	11,235,843	0.003908	1,253,801	4,900	56.01
57.00	05700	CT SCAN	35,577	50,731,515	0.000701	6,260,427	4,389	57.00
58.00	05800	MRI	49,543	13,883,849	0.003568	1,107,838	3,953	58.00
59.00	05900	CARDIAC CATHETERIZATION	48,732	12,972,101	0.003757	3,658,573	13,745	59.00
60.00	06000	LABORATORY	261,006	74,311,318	0.003512	13,947,707	48,984	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	36,831	15,763,766	0.002336	5,934,548	13,863	65.00
66.00	06600	PHYSICAL THERAPY	220,191	21,174,044	0.010399	721,481	7,503	66.00
67.00	06700	OCCUPATIONAL THERAPY	35,460	2,523,957	0.014049	309,778	4,352	67.00
68.00	06800	SPEECH PATHOLOGY	21,905	1,228,083	0.017837	55,390	988	68.00
69.00	06900	ELECTROCARDIOLOGY	47,896	19,879,490	0.002409	4,387,646	10,570	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	21,938	2,072,383	0.010586	131,036	1,387	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	107,034	9,256,284	0.011563	2,111,883	24,420	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	84,332	14,973,158	0.005632	4,557,777	25,669	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	76,167	22,233,285	0.003426	5,619,286	19,252	73.00
73.01	07301	OUTPATIENT PHARMACY	0	0	0.000000	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
76.00	03950	LITHOTRIPSY	0	0	0.000000	0	0	76.00
76.01	03951	CARDIAC REHABILITATION	72,723	2,151,701	0.033798	1,308	44	76.01
76.02	03020	GASTROINTESTINAL SERVICES	87,595	12,278,814	0.007134	1,025,295	7,314	76.02
76.03	03030	ANGIOCARDIOGRAPHY	0	0	0.000000	0	0	76.03
76.05	03954	INPATIENT RENAL DIALYSIS	0	0	0.000000	0	0	76.05
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	4	33,183	0.000121	0	0	90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES	0	0	0.000000	0	0	90.01
90.02	04950	WOUND CARE	50,827	5,170,732	0.009830	8,015	79	90.02
90.03	09003	RIVER FOREST	0	0	0.000000	0	0	90.03
91.00	09100	EMERGENCY	273,882	62,352,446	0.004392	7,116,725	31,257	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	723,023	10,314,950	0.070095	1,483,625	103,995	92.00
200.00		Total (lines 50 through 199)	3,429,902	451,085,740		71,870,873	488,177	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part III Date/Time Prepared: 11/29/2018 6:55 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0		44.00
200.00		Total (lines 30 through 199)	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	21,720	0.00	9,685	30.00
31.00	03100	INTENSIVE CARE UNIT		0	3,834	0.00	1,660	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	3,379	0.00	3,078	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	5,510	0.00	2,986	41.00
43.00	04300	NURSERY		0	0	0.00	0	43.00
44.00	04400	SKILLED NURSING FACILITY		0	9,221	0.00	6,334	44.00
200.00		Total (lines 30 through 199)		0	43,664		23,743	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	41.00
43.00	04300	NURSERY	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	44.00
200.00		Total (lines 30 through 199)	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV | Date/Time Prepared: 11/29/2018 6:55 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
56.01	03630	ULTRASOUND	0	0	0	0	0	56.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	OUTPATIENT PHARMACY	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	LITHOTRIPSY	0	0	0	0	0	76.00
76.01	03951	CARDIAC REHABILITATION	0	0	0	0	0	76.01
76.02	03020	GASTROINTESTINAL SERVICES	0	0	0	0	0	76.02
76.03	03030	ANGIOCARDIOGRAPHY	0	0	0	0	0	76.03
76.05	03954	INPATIENT RENAL DIALYSIS	0	0	0	0	0	76.05
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES	0	0	0	0	0	90.01
90.02	04950	WOUND CARE	0	0	0	0	0	90.02
90.03	09003	RIVER FOREST	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV | Date/Time Prepared: 11/29/2018 6:55 pm

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	26,744,596	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	10,813,082	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	20,709,706	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	22,378,903	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	5,898,551	0.000000	56.00
56.01	03630	ULTRASOUND	0	0	0	11,235,843	0.000000	56.01
57.00	05700	CT SCAN	0	0	0	50,731,515	0.000000	57.00
58.00	05800	MRI	0	0	0	13,883,849	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	12,972,101	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	74,311,318	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	15,763,766	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	21,174,044	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,523,957	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,228,083	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	19,879,490	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	2,072,383	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	9,256,284	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	14,973,158	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	22,233,285	0.000000	73.00
73.01	07301	OUTPATIENT PHARMACY	0	0	0	0	0.000000	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0.000000	74.00
76.00	03950	LITHOTRIPSY	0	0	0	0	0.000000	76.00
76.01	03951	CARDIAC REHABILITATION	0	0	0	2,151,701	0.000000	76.01
76.02	03020	GASTROINTESTINAL SERVICES	0	0	0	12,278,814	0.000000	76.02
76.03	03030	ANGIOCARDIOGRAPHY	0	0	0	0	0.000000	76.03
76.05	03954	INPATIENT RENAL DIALYSIS	0	0	0	0	0.000000	76.05
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	33,183	0.000000	90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES	0	0	0	0	0.000000	90.01
90.02	04950	WOUND CARE	0	0	0	5,170,732	0.000000	90.02
90.03	09003	RIVER FOREST	0	0	0	0	0.000000	90.03
91.00	09100	EMERGENCY	0	0	0	62,352,446	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	10,314,950	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	451,085,740		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV | Date/Time Prepared: 11/29/2018 6:55 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	4,059,194	0	4,530,476	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	1,666,226	0	1,260,992	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	3,271,174	0	3,263,820	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	2,451,935	0	2,577,861	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	730,205	0	1,518,720	0	56.00
56.01	03630	ULTRASOUND	0.000000	1,253,801	0	1,923,124	0	56.01
57.00	05700	CT SCAN	0.000000	6,260,427	0	9,581,481	0	57.00
58.00	05800	MRI	0.000000	1,107,838	0	3,406,285	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	3,658,573	0	3,156,773	0	59.00
60.00	06000	LABORATORY	0.000000	13,947,707	0	4,398,269	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	5,934,548	0	335,507	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	721,481	0	52,190	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	309,778	0	29,074	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	55,390	0	88,180	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	4,387,646	0	3,466,352	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	131,036	0	400,198	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	2,111,883	0	1,042,160	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	4,557,777	0	1,301,602	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	5,619,286	0	1,928,120	0	73.00
73.01	07301	OUTPATIENT PHARMACY	0.000000	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00	03950	LITHOTRIPSY	0.000000	0	0	0	0	76.00
76.01	03951	CARDIAC REHABILITATION	0.000000	1,308	0	915,520	0	76.01
76.02	03020	GASTROINTESTINAL SERVICES	0.000000	1,025,295	0	2,403,721	0	76.02
76.03	03030	ANGIOCARDIOGRAPHY	0.000000	0	0	0	0	76.03
76.05	03954	INPATIENT RENAL DIALYSIS	0.000000	0	0	0	0	76.05
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	12,482	0	90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES	0.000000	0	0	0	0	90.01
90.02	04950	WOUND CARE	0.000000	8,015	0	2,346,201	0	90.02
90.03	09003	RIVER FOREST	0.000000	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.000000	7,116,725	0	7,264,927	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	1,483,625	0	1,529,842	0	92.00
200.00		Total (lines 50 through 199)		71,870,873	0	58,733,877	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part V Date/Time Prepared: 11/29/2018 6:55 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.384569	4,530,476	8,493	0	1,742,281	50.00
51.00	05100	RECOVERY ROOM	0.085613	1,260,992	0	0	107,957	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.007434	3,263,820	0	0	24,263	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.161927	2,577,861	0	0	417,425	54.00
56.00	05600	RADIOISOTOPE	0.075937	1,518,720	0	0	115,327	56.00
56.01	03630	ULTRASOUND	0.074966	1,923,124	0	0	144,169	56.01
57.00	05700	CT SCAN	0.020300	9,581,481	0	0	194,504	57.00
58.00	05800	MRI	0.040742	3,406,285	0	0	138,779	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.099105	3,156,773	0	0	312,852	59.00
60.00	06000	LABORATORY	0.113732	4,398,269	2,211	0	500,224	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.117176	335,507	0	0	39,313	65.00
66.00	06600	PHYSICAL THERAPY	0.193083	52,190	0	0	10,077	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.219065	29,074	0	0	6,369	67.00
68.00	06800	SPEECH PATHOLOGY	0.343930	88,180	0	0	30,328	68.00
69.00	06900	ELECTROCARDIOLOGY	0.047346	3,466,352	0	0	164,118	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.124697	400,198	0	0	49,903	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.064443	1,042,160	0	0	1,109,320	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.514547	1,301,602	0	0	669,735	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.257738	1,928,120	0	14,823	496,950	73.00
73.01	07301	OUTPATIENT PHARMACY	0.000000	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00	03950	LITHOTRIPSY	0.000000	0	0	0	0	76.00
76.01	03951	CARDIAC REHABILITATION	0.278584	915,520	0	0	255,049	76.01
76.02	03020	GASTROINTESTINAL SERVICES	0.137989	2,403,721	0	0	331,687	76.02
76.03	03030	ANGIOCARDIOGRAPHY	0.000000	0	0	0	0	76.03
76.05	03954	INPATIENT RENAL DIALYSIS	0.000000	0	0	0	0	76.05
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.004671	12,482	0	0	58	90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES	0.000000	0	0	0	0	90.01
90.02	04950	WOUND CARE	0.275520	2,346,201	0	0	646,425	90.02
90.03	09003	RIVER FOREST	0.000000	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.104809	7,264,927	0	18	761,430	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.279317	1,529,842	0	0	427,311	92.00
200.00		Subtotal (see instructions)		58,733,877	10,704	14,841	8,695,854	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		58,733,877	10,704	14,841	8,695,854	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part V Date/Time Prepared: 11/29/2018 6:55 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	3,266	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
56.01	03630	ULTRASOUND	0	0		56.01
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	251	0		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	3,820		73.00
73.01	07301	OUTPATIENT PHARMACY	0	0		73.01
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	LITHOTRIPSY	0	0		76.00
76.01	03951	CARDIAC REHABILITATION	0	0		76.01
76.02	03020	GASTROINTESTINAL SERVICES	0	0		76.02
76.03	03030	ANGIOCARDIOGRAPHY	0	0		76.03
76.05	03954	INPATIENT RENAL DIALYSIS	0	0		76.05
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0		76.99
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES	0	0		90.01
90.02	04950	WOUND CARE	0	0		90.02
90.03	09003	RIVER FOREST	0	0		90.03
91.00	09100	EMERGENCY	0	2		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	3,517	3,822		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	3,517	3,822		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0008 | Component CCN: 14-S008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part II | Date/Time Prepared: 11/29/2018 6:55 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	821,514	26,744,596	0.030717	834	26	50.00
51.00	05100	RECOVERY ROOM	35,978	10,813,082	0.003327	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	14,824	20,709,706	0.000716	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	219,420	22,378,903	0.009805	27,483	269	54.00
56.00	05600	RADIOISOTOPE	39,586	5,898,551	0.006711	0	0	56.00
56.01	03630	ULTRASOUND	43,914	11,235,843	0.003908	17,652	69	56.01
57.00	05700	CT SCAN	35,577	50,731,515	0.000701	131,342	92	57.00
58.00	05800	MRI	49,543	13,883,849	0.003568	86,396	308	58.00
59.00	05900	CARDIAC CATHETERIZATION	48,732	12,972,101	0.003757	5,195	20	59.00
60.00	06000	LABORATORY	261,006	74,311,318	0.003512	731,373	2,569	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	36,831	15,763,766	0.002336	146,321	342	65.00
66.00	06600	PHYSICAL THERAPY	220,191	21,174,044	0.010399	54,371	565	66.00
67.00	06700	OCCUPATIONAL THERAPY	35,460	2,523,957	0.014049	17,335	244	67.00
68.00	06800	SPEECH PATHOLOGY	21,905	1,228,083	0.017837	8,107	145	68.00
69.00	06900	ELECTROCARDIOLOGY	47,896	19,879,490	0.002409	43,980	106	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	21,938	2,072,383	0.010586	19,485	206	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	107,034	9,256,284	0.011563	6,120	71	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	84,332	14,973,158	0.005632	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	76,167	22,233,285	0.003426	142,744	489	73.00
73.01	07301	OUTPATIENT PHARMACY	0	0	0.000000	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
76.00	03950	LITHOTRIPSY	0	0	0.000000	0	0	76.00
76.01	03951	CARDIAC REHABILITATION	72,723	2,151,701	0.033798	0	0	76.01
76.02	03020	GASTROINTESTINAL SERVICES	87,595	12,278,814	0.007134	0	0	76.02
76.03	03030	ANGIOCARDIOGRAPHY	0	0	0.000000	0	0	76.03
76.05	03954	INPATIENT RENAL DIALYSIS	0	0	0.000000	0	0	76.05
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	4	33,183	0.000121	0	0	90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES	0	0	0.000000	0	0	90.01
90.02	04950	WOUND CARE	50,827	5,170,732	0.009830	0	0	90.02
90.03	09003	RIVER FOREST	0	0	0.000000	0	0	90.03
91.00	09100	EMERGENCY	273,882	62,352,446	0.004392	101,674	447	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	10,314,950	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	2,706,879	451,085,740		1,540,412	5,968	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0008 | Component CCN: 14-S008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV Date/Time Prepared: 11/29/2018 6:55 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
56.01	03630	ULTRASOUND	0	0	0	0	0	56.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	OUTPATIENT PHARMACY	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	LITHOTRIPSY	0	0	0	0	0	76.00
76.01	03951	CARDIAC REHABILITATION	0	0	0	0	0	76.01
76.02	03020	GASTROINTESTINAL SERVICES	0	0	0	0	0	76.02
76.03	03030	ANGIOCARDIOGRAPHY	0	0	0	0	0	76.03
76.05	03954	INPATIENT RENAL DIALYSIS	0	0	0	0	0	76.05
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES	0	0	0	0	0	90.01
90.02	04950	WOUND CARE	0	0	0	0	0	90.02
90.03	09003	RIVER FOREST	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0008 | Component CCN: 14-S008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV | Date/Time Prepared: 11/29/2018 6:55 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	26,744,596	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	10,813,082	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	20,709,706	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	22,378,903	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	5,898,551	0.000000	56.00
56.01	03630	ULTRASOUND	0	0	0	11,235,843	0.000000	56.01
57.00	05700	CT SCAN	0	0	0	50,731,515	0.000000	57.00
58.00	05800	MRI	0	0	0	13,883,849	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	12,972,101	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	74,311,318	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	15,763,766	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	21,174,044	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,523,957	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,228,083	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	19,879,490	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	2,072,383	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	9,256,284	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	14,973,158	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	22,233,285	0.000000	73.00
73.01	07301	OUTPATIENT PHARMACY	0	0	0	0	0.000000	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0.000000	74.00
76.00	03950	LITHOTRIPSY	0	0	0	0	0.000000	76.00
76.01	03951	CARDIAC REHABILITATION	0	0	0	2,151,701	0.000000	76.01
76.02	03020	GASTROINTESTINAL SERVICES	0	0	0	12,278,814	0.000000	76.02
76.03	03030	ANGIOCARDIOGRAPHY	0	0	0	0	0.000000	76.03
76.05	03954	INPATIENT RENAL DIALYSIS	0	0	0	0	0.000000	76.05
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	33,183	0.000000	90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES	0	0	0	0	0.000000	90.01
90.02	04950	WOUND CARE	0	0	0	5,170,732	0.000000	90.02
90.03	09003	RIVER FOREST	0	0	0	0	0.000000	90.03
91.00	09100	EMERGENCY	0	0	0	62,352,446	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	10,314,950	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	451,085,740		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0008 | Component CCN: 14-S008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV Date/Time Prepared: 11/29/2018 6:55 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	834	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	27,483	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	0	0	0	0	56.00
56.01	03630	ULTRASOUND	0.000000	17,652	0	0	0	56.01
57.00	05700	CT SCAN	0.000000	131,342	0	0	0	57.00
58.00	05800	MRI	0.000000	86,396	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	5,195	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	731,373	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.000000	146,321	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	54,371	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	17,335	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	8,107	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	43,980	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	19,485	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	6,120	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	142,744	0	0	0	73.00
73.01	07301	OUTPATIENT PHARMACY	0.000000	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00	03950	LITHOTRIPSY	0.000000	0	0	0	0	76.00
76.01	03951	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.01
76.02	03020	GASTROINTESTINAL SERVICES	0.000000	0	0	0	0	76.02
76.03	03030	ANGIOCARDIOGRAPHY	0.000000	0	0	0	0	76.03
76.05	03954	INPATIENT RENAL DIALYSIS	0.000000	0	0	0	0	76.05
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES	0.000000	0	0	0	0	90.01
90.02	04950	WOUND CARE	0.000000	0	0	0	0	90.02
90.03	09003	RIVER FOREST	0.000000	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.000000	101,674	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		1,540,412	0	0	0	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0008 | Component CCN: 14-T008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part II | Date/Time Prepared: 11/29/2018 6:55 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	821,514	26,744,596	0.030717	34,670	1,065	50.00
51.00	05100	RECOVERY ROOM	35,978	10,813,082	0.003327	3,740	12	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	14,824	20,709,706	0.000716	4,609	3	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	219,420	22,378,903	0.009805	52,060	510	54.00
56.00	05600	RADIOISOTOPE	39,586	5,898,551	0.006711	5,704	38	56.00
56.01	03630	ULTRASOUND	43,914	11,235,843	0.003908	43,697	171	56.01
57.00	05700	CT SCAN	35,577	50,731,515	0.000701	95,430	67	57.00
58.00	05800	MRI	49,543	13,883,849	0.003568	11,353	41	58.00
59.00	05900	CARDIAC CATHETERIZATION	48,732	12,972,101	0.003757	96,765	364	59.00
60.00	06000	LABORATORY	261,006	74,311,318	0.003512	678,605	2,383	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	36,831	15,763,766	0.002336	639,635	1,494	65.00
66.00	06600	PHYSICAL THERAPY	220,191	21,174,044	0.010399	503,791	5,239	66.00
67.00	06700	OCCUPATIONAL THERAPY	35,460	2,523,957	0.014049	226,775	3,186	67.00
68.00	06800	SPEECH PATHOLOGY	21,905	1,228,083	0.017837	109,975	1,962	68.00
69.00	06900	ELECTROCARDIOLOGY	47,896	19,879,490	0.002409	57,870	139	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	21,938	2,072,383	0.010586	3,897	41	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	107,034	9,256,284	0.011563	59,951	693	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	84,332	14,973,158	0.005632	13,464	76	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	76,167	22,233,285	0.003426	484,772	1,661	73.00
73.01	07301	OUTPATIENT PHARMACY	0	0	0.000000	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0	0	74.00
76.00	03950	LITHOTRIPSY	0	0	0.000000	0	0	76.00
76.01	03951	CARDIAC REHABILITATION	72,723	2,151,701	0.033798	0	0	76.01
76.02	03020	GASTROINTESTINAL SERVICES	87,595	12,278,814	0.007134	426	3	76.02
76.03	03030	ANGIOCARDIOGRAPHY	0	0	0.000000	0	0	76.03
76.05	03954	INPATIENT RENAL DIALYSIS	0	0	0.000000	0	0	76.05
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0.000000	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	4	33,183	0.000121	0	0	90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES	0	0	0.000000	0	0	90.01
90.02	04950	WOUND CARE	50,827	5,170,732	0.009830	0	0	90.02
90.03	09003	RIVER FOREST	0	0	0.000000	0	0	90.03
91.00	09100	EMERGENCY	273,882	62,352,446	0.004392	5,716	25	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	10,314,950	0.000000	0	0	92.00
200.00		Total (lines 50 through 199)	2,706,879	451,085,740		3,132,905	19,173	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0008 | Component CCN: 14-T008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV Date/Time Prepared: 11/29/2018 6:55 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
56.01	03630	ULTRASOUND	0	0	0	0	0	56.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	OUTPATIENT PHARMACY	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	LITHOTRIPSY	0	0	0	0	0	76.00
76.01	03951	CARDIAC REHABILITATION	0	0	0	0	0	76.01
76.02	03020	GASTROINTESTINAL SERVICES	0	0	0	0	0	76.02
76.03	03030	ANGIOCARDIOGRAPHY	0	0	0	0	0	76.03
76.05	03954	INPATIENT RENAL DIALYSIS	0	0	0	0	0	76.05
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES	0	0	0	0	0	90.01
90.02	04950	WOUND CARE	0	0	0	0	0	90.02
90.03	09003	RIVER FOREST	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0008 | Component CCN: 14-T008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV | Date/Time Prepared: 11/29/2018 6:55 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	26,744,596	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	10,813,082	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	20,709,706	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	22,378,903	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	5,898,551	0.000000	56.00
56.01	03630	ULTRASOUND	0	0	0	11,235,843	0.000000	56.01
57.00	05700	CT SCAN	0	0	0	50,731,515	0.000000	57.00
58.00	05800	MRI	0	0	0	13,883,849	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	12,972,101	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	74,311,318	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	15,763,766	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	21,174,044	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,523,957	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,228,083	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	19,879,490	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	2,072,383	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	9,256,284	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	14,973,158	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	22,233,285	0.000000	73.00
73.01	07301	OUTPATIENT PHARMACY	0	0	0	0	0.000000	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0.000000	74.00
76.00	03950	LITHOTRIPSY	0	0	0	0	0.000000	76.00
76.01	03951	CARDIAC REHABILITATION	0	0	0	2,151,701	0.000000	76.01
76.02	03020	GASTROINTESTINAL SERVICES	0	0	0	12,278,814	0.000000	76.02
76.03	03030	ANGIOCARDIOGRAPHY	0	0	0	0	0.000000	76.03
76.05	03954	INPATIENT RENAL DIALYSIS	0	0	0	0	0.000000	76.05
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	33,183	0.000000	90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES	0	0	0	0	0.000000	90.01
90.02	04950	WOUND CARE	0	0	0	5,170,732	0.000000	90.02
90.03	09003	RIVER FOREST	0	0	0	0	0.000000	90.03
91.00	09100	EMERGENCY	0	0	0	62,352,446	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	10,314,950	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	451,085,740		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0008 | Component CCN: 14-T008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV Date/Time Prepared: 11/29/2018 6:55 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	34,670	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	3,740	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	4,609	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	52,060	0	1,103	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	5,704	0	0	0	56.00
56.01	03630	ULTRASOUND	0.000000	43,697	0	0	0	56.01
57.00	05700	CT SCAN	0.000000	95,430	0	0	0	57.00
58.00	05800	MRI	0.000000	11,353	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	96,765	0	88	0	59.00
60.00	06000	LABORATORY	0.000000	678,605	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.000000	639,635	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	503,791	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	226,775	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	109,975	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	57,870	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	3,897	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	59,951	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	13,464	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	484,772	0	500	0	73.00
73.01	07301	OUTPATIENT PHARMACY	0.000000	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00	03950	LITHOTRIPSY	0.000000	0	0	0	0	76.00
76.01	03951	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.01
76.02	03020	GASTROINTESTINAL SERVICES	0.000000	426	0	0	0	76.02
76.03	03030	ANGIOCARDIOGRAPHY	0.000000	0	0	0	0	76.03
76.05	03954	INPATIENT RENAL DIALYSIS	0.000000	0	0	0	0	76.05
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES	0.000000	0	0	0	0	90.01
90.02	04950	WOUND CARE	0.000000	0	0	0	0	90.02
90.03	09003	RIVER FOREST	0.000000	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.000000	5,716	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		3,132,905	0	1,691	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0008 | Component CCN: 14-T008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part V | Date/Time Prepared: 11/29/2018 6:55 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.384569	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.085613	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.007434	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.161927	1,103	0	0	179	54.00
56.00	05600	RADIOISOTOPE	0.075937	0	0	0	0	56.00
56.01	03630	ULTRASOUND	0.074966	0	0	0	0	56.01
57.00	05700	CT SCAN	0.020300	0	0	0	0	57.00
58.00	05800	MRI	0.040742	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.099105	88	0	0	9	59.00
60.00	06000	LABORATORY	0.113732	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	0.117176	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.193083	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.219065	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.343930	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.047346	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.124697	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.064443	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.514547	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.257738	500	0	0	129	73.00
73.01	07301	OUTPATIENT PHARMACY	0.000000	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00	03950	LITHOTRIPSY	0.000000	0	0	0	0	76.00
76.01	03951	CARDIAC REHABILITATION	0.278584	0	0	0	0	76.01
76.02	03020	GASTROINTESTINAL SERVICES	0.137989	0	0	0	0	76.02
76.03	03030	ANGIOCARDIOGRAPHY	0.000000	0	0	0	0	76.03
76.05	03954	INPATIENT RENAL DIALYSIS	0.000000	0	0	0	0	76.05
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.004671	0	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES	0.000000	0	0	0	0	90.01
90.02	04950	WOUND CARE	0.275520	0	0	0	0	90.02
90.03	09003	RIVER FOREST	0.000000	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.104809	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.279317	0	0	0	0	92.00
200.00		Subtotal (see instructions)		1,691	0	0	317	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		1,691	0	0	317	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 14-0008 | Component CCN: 14-T008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part V | Date/Time Prepared: 11/29/2018 6:55 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
56.00	05600	RADIOISOTOPE	0	0		56.00
56.01	03630	ULTRASOUND	0	0		56.01
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62.30
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0		73.00
73.01	07301	OUTPATIENT PHARMACY	0	0		73.01
74.00	07400	RENAL DIALYSIS	0	0		74.00
76.00	03950	LITHOTRIPSY	0	0		76.00
76.01	03951	CARDIAC REHABILITATION	0	0		76.01
76.02	03020	GASTROINTESTINAL SERVICES	0	0		76.02
76.03	03030	ANGIOCARDIOGRAPHY	0	0		76.03
76.05	03954	INPATIENT RENAL DIALYSIS	0	0		76.05
76.97	07697	CARDIAC REHABILITATION	0	0		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0		76.98
76.99	07699	LITHOTRIPSY	0	0		76.99
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0	0		90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES	0	0		90.01
90.02	04950	WOUND CARE	0	0		90.02
90.03	09003	RIVER FOREST	0	0		90.03
91.00	09100	EMERGENCY	0	0		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
200.00		Subtotal (see instructions)	0	0		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	0	0		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0008 | Component CCN: 14-5526 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV | Date/Time Prepared: 11/29/2018 6:55 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
56.01	03630	ULTRASOUND	0	0	0	0	0	56.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	OUTPATIENT PHARMACY	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	LITHOTRIPSY	0	0	0	0	0	76.00
76.01	03951	CARDIAC REHABILITATION	0	0	0	0	0	76.01
76.02	03020	GASTROINTESTINAL SERVICES	0	0	0	0	0	76.02
76.03	03030	ANGIOCARDIOGRAPHY	0	0	0	0	0	76.03
76.05	03954	INPATIENT RENAL DIALYSIS	0	0	0	0	0	76.05
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES	0	0	0	0	0	90.01
90.02	04950	WOUND CARE	0	0	0	0	0	90.02
90.03	09003	RIVER FOREST	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
200.00		Total (lines 50 through 199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0008 | Component CCN: 14-5526 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV | Date/Time Prepared: 11/29/2018 6:55 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	26,744,596	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	10,813,082	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	20,709,706	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	22,378,903	0.000000	54.00
56.00	05600	RADIOISOTOPE	0	0	0	5,898,551	0.000000	56.00
56.01	03630	ULTRASOUND	0	0	0	11,235,843	0.000000	56.01
57.00	05700	CT SCAN	0	0	0	50,731,515	0.000000	57.00
58.00	05800	MRI	0	0	0	13,883,849	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	12,972,101	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	74,311,318	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	15,763,766	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	21,174,044	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	2,523,957	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	1,228,083	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	19,879,490	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	2,072,383	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	9,256,284	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	14,973,158	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	22,233,285	0.000000	73.00
73.01	07301	OUTPATIENT PHARMACY	0	0	0	0	0.000000	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0.000000	74.00
76.00	03950	LITHOTRIPSY	0	0	0	0	0.000000	76.00
76.01	03951	CARDIAC REHABILITATION	0	0	0	2,151,701	0.000000	76.01
76.02	03020	GASTROINTESTINAL SERVICES	0	0	0	12,278,814	0.000000	76.02
76.03	03030	ANGIOCARDIOGRAPHY	0	0	0	0	0.000000	76.03
76.05	03954	INPATIENT RENAL DIALYSIS	0	0	0	0	0.000000	76.05
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIPSY	0	0	0	0	0.000000	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	33,183	0.000000	90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES	0	0	0	0	0.000000	90.01
90.02	04950	WOUND CARE	0	0	0	5,170,732	0.000000	90.02
90.03	09003	RIVER FOREST	0	0	0	0	0.000000	90.03
91.00	09100	EMERGENCY	0	0	0	62,352,446	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	10,314,950	0.000000	92.00
200.00		Total (lines 50 through 199)	0	0	0	451,085,740		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0008 | Component CCN: 14-5526 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D Part IV | Date/Time Prepared: 11/29/2018 6:55 pm

Title XVIII | Skilled Nursing Facility | 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	46,066	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	19	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	40,004	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	112,279	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0.000000	10,757	0	0	0	56.00
56.01	03630	ULTRASOUND	0.000000	106,530	0	0	0	56.01
57.00	05700	CT SCAN	0.000000	92,138	0	0	0	57.00
58.00	05800	MRI	0.000000	8,523	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	43,403	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	835,379	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.000000	975,679	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	821,759	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	376,104	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	153,653	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	100,588	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	6,495	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	235,422	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	704,034	0	0	0	73.00
73.01	07301	OUTPATIENT PHARMACY	0.000000	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
76.00	03950	LITHOTRIPSY	0.000000	0	0	0	0	76.00
76.01	03951	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.01
76.02	03020	GASTROINTESTINAL SERVICES	0.000000	36,007	0	0	0	76.02
76.03	03030	ANGIOCARDIOGRAPHY	0.000000	0	0	0	0	76.03
76.05	03954	INPATIENT RENAL DIALYSIS	0.000000	0	0	0	0	76.05
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES	0.000000	0	0	0	0	90.01
90.02	04950	WOUND CARE	0.000000	437	0	0	0	90.02
90.03	09003	RIVER FOREST	0.000000	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.000000	7,094	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
200.00		Total (lines 50 through 199)		4,712,370	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 11/29/2018 6:55 pm

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	21,720	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	21,720	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	19,145	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)	9,685	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)	24,302,362	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)	24,302,362	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)	24,302,362	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)	1,118.89	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	10,836,450	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)	10,836,450	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 11/29/2018 6:55 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	6,009,309	3,834	1,567.37	1,660	2,601,834	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	12,887,097	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	26,325,381	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)	2,833,277	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	488,177	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	3,321,454	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	23,003,927	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)	2,575	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,118.89	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	2,881,142	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 11/29/2018 6:55 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	6,098,671	24,302,362	0.250950	2,881,142	723,023	90.00
91.00	Nursing School cost	0	24,302,362	0.000000	2,881,142	0	91.00
92.00	Allied health cost	0	24,302,362	0.000000	2,881,142	0	92.00
93.00	All other Medical Education	0	24,302,362	0.000000	2,881,142	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-0008 Component CCN: 14-S008	Period: From 07/01/2017 To 06/30/2018	Worksheet D-1 Date/Time Prepared: 11/29/2018 6:55 pm
	Title XVIII	Subprovider - IPF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	3,379	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3,379	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)	3,379	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	3,078	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	2,336,991	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	2,336,991	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	2,336,991	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)	691.62	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,128,806	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2,128,806	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0008 | Component CCN: 14-S008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 11/29/2018 6:55 pm

Title XVIII | Subprovider - IPF | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	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
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)	188,677	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	2,317,483	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)	109,115	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	5,968	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	115,083	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	2,202,400	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: 14-0008 | Component CCN: 14-S008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 11/29/2018 6:55 pm

Title XVIII | Subprovider - IPF | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	119,798	2,336,991	0.051262	0	0	90.00
91.00	Nursing School cost	0	2,336,991	0.000000	0	0	91.00
92.00	Allied health cost	0	2,336,991	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,336,991	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-0008 Component CCN: 14-T008	Period: From 07/01/2017 To 06/30/2018	Worksheet D-1 Date/Time Prepared: 11/29/2018 6:55 pm
	Title XVIII	Subprovider - IRF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	5,510	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,510	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	5,510	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)	2,986	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,523,482	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,523,482	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	4,523,482	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)	820.96	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	2,451,387	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	2,451,387	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0008 | Component CCN: 14-T008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 11/29/2018 6:55 pm

Title XVIII | Subprovider - IRF | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	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
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)	574,290	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	3,025,677	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)	138,730	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	19,173	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	157,903	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	2,867,774	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: 14-0008 | Component CCN: 14-T008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 11/29/2018 6:55 pm

Title XVIII | Subprovider - IRF | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	255,968	4,523,482	0.056586	0	0	90.00
91.00	Nursing School cost	0	4,523,482	0.000000	0	0	91.00
92.00	Allied health cost	0	4,523,482	0.000000	0	0	92.00
93.00	All other Medical Education	0	4,523,482	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-0008 Component CCN: 14-5526	Period: From 07/01/2017 To 06/30/2018	Worksheet D-1 Date/Time Prepared: 11/29/2018 6:55 pm
	Title XVIII	Skilled Nursing Facility	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	9,221	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	9,221	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)	9,221	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)	6,334	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)	6,242,939	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)	6,242,939	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)	6,242,939	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0008 | Component CCN: 14-5526 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-1 | Date/Time Prepared: 11/29/2018 6:55 pm

Title XVIII | Skilled Nursing Facility | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)		48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)		49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)		50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)		51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)		52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)		53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges		54.00
55.00	Target amount per discharge		55.00
56.00	Target amount (line 54 x line 55)		56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)		57.00
58.00	Bonus payment (see instructions)		58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket		59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket		60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)		61.00
62.00	Relief payment (see instructions)		62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)		63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)		64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)		65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)		66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)		67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)		68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)		69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)	6,242,939	70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)	677.03	71.00
72.00	Program routine service cost (line 9 x line 71)	4,288,308	72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)	0	73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)	4,288,308	74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)	0	75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)	0.00	76.00
77.00	Program capital-related costs (line 9 x line 76)	0	77.00
78.00	Inpatient routine service cost (line 74 minus line 77)	0	78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)	0	79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)	0	80.00
81.00	Inpatient routine service cost per diem limitation	0.00	81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)	0	82.00
83.00	Reasonable inpatient routine service costs (see instructions)	4,288,308	83.00
84.00	Program inpatient ancillary services (see instructions)	998,211	84.00
85.00	Utilization review - physician compensation (see instructions)	0	85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)	5,286,519	86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0008
Component CCN: 14-5526

Period:
From 07/01/2017
To 06/30/2018

Worksheet D-1
Date/Time Prepared:
11/29/2018 6:55 pm

Title XVIII | Skilled Nursing Facility | PPS

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

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-0008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-3 | Date/Time Prepared: 11/29/2018 6:55 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		31,358,920		30.00
31.00	03100	INTENSIVE CARE UNIT		7,459,000		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.384569	4,059,194	1,561,040	50.00
51.00	05100	RECOVERY ROOM	0.085613	1,666,226	142,651	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.007434	3,271,174	24,318	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.161927	2,451,935	397,034	54.00
56.00	05600	RADIOISOTOPE	0.075937	730,205	55,450	56.00
56.01	03630	ULTRASOUND	0.074966	1,253,801	93,992	56.01
57.00	05700	CT SCAN	0.020300	6,260,427	127,087	57.00
58.00	05800	MRI	0.040742	1,107,838	45,136	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.099105	3,658,573	362,583	59.00
60.00	06000	LABORATORY	0.113732	13,947,707	1,586,301	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.117176	5,934,548	695,387	65.00
66.00	06600	PHYSICAL THERAPY	0.193083	721,481	139,306	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.219065	309,778	67,862	67.00
68.00	06800	SPEECH PATHOLOGY	0.343930	55,390	19,050	68.00
69.00	06900	ELECTROCARDIOLOGY	0.047346	4,387,646	207,737	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.124697	131,036	16,340	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.064443	2,111,883	2,247,979	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.514547	4,557,777	2,345,190	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.257738	5,619,286	1,448,304	73.00
73.01	07301	OUTPATIENT PHARMACY	0.000000	0	0	73.01
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
76.00	03950	LITHOTRIPSY	0.000000	0	0	76.00
76.01	03951	CARDIAC REHABILITATION	0.278584	1,308	364	76.01
76.02	03020	GASTROINTESTINAL SERVICES	0.137989	1,025,295	141,479	76.02
76.03	03030	ANGIOCARDIOGRAPHY	0.000000	0	0	76.03
76.05	03954	INPATIENT RENAL DIALYSIS	0.000000	0	0	76.05
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.004671	0	0	90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES	0.000000	0	0	90.01
90.02	04950	WOUND CARE	0.275520	8,015	2,208	90.02
90.03	09003	RIVER FOREST	0.000000	0	0	90.03
91.00	09100	EMERGENCY	0.104809	7,116,725	745,897	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.279317	1,483,625	414,402	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		71,870,873	12,887,097	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)		71,870,873		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-0008 | Component CCN: 14-S008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-3 | Date/Time Prepared: 11/29/2018 6:55 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		8,098,546		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.384569	834	321	50.00
51.00	05100	RECOVERY ROOM	0.085613	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.007434	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.161927	27,483	4,450	54.00
56.00	05600	RADIOISOTOPE	0.075937	0	0	56.00
56.01	03630	ULTRASOUND	0.074966	17,652	1,323	56.01
57.00	05700	CT SCAN	0.020300	131,342	2,666	57.00
58.00	05800	MRI	0.040742	86,396	3,520	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.099105	5,195	515	59.00
60.00	06000	LABORATORY	0.113732	731,373	83,181	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.117176	146,321	17,145	65.00
66.00	06600	PHYSICAL THERAPY	0.193083	54,371	10,498	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.219065	17,335	3,797	67.00
68.00	06800	SPEECH PATHOLOGY	0.343930	8,107	2,788	68.00
69.00	06900	ELECTROCARDIOLOGY	0.047346	43,980	2,082	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.124697	19,485	2,430	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.064443	6,120	6,514	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.514547	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.257738	142,744	36,791	73.00
73.01	07301	OUTPATIENT PHARMACY	0.000000	0	0	73.01
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
76.00	03950	LITHOTRIPSY	0.000000	0	0	76.00
76.01	03951	CARDIAC REHABILITATION	0.278584	0	0	76.01
76.02	03020	GASTROINTESTINAL SERVICES	0.137989	0	0	76.02
76.03	03030	ANGIOCARDIOGRAPHY	0.000000	0	0	76.03
76.05	03954	INPATIENT RENAL DIALYSIS	0.000000	0	0	76.05
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.004671	0	0	90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES	0.000000	0	0	90.01
90.02	04950	WOUND CARE	0.275520	0	0	90.02
90.03	09003	RIVER FOREST	0.000000	0	0	90.03
91.00	09100	EMERGENCY	0.104809	101,674	10,656	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.279317	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,540,412	188,677	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)		1,540,412		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-0008 | Component CCN: 14-T008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-3 | Date/Time Prepared: 11/29/2018 6:55 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		7,428,491		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.384569	34,670	13,333	50.00
51.00	05100	RECOVERY ROOM	0.085613	3,740	320	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.007434	4,609	34	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.161927	52,060	8,430	54.00
56.00	05600	RADIOISOTOPE	0.075937	5,704	433	56.00
56.01	03630	ULTRASOUND	0.074966	43,697	3,276	56.01
57.00	05700	CT SCAN	0.020300	95,430	1,937	57.00
58.00	05800	MRI	0.040742	11,353	463	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.099105	96,765	9,590	59.00
60.00	06000	LABORATORY	0.113732	678,605	77,179	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.117176	639,635	74,950	65.00
66.00	06600	PHYSICAL THERAPY	0.193083	503,791	97,273	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.219065	226,775	49,678	67.00
68.00	06800	SPEECH PATHOLOGY	0.343930	109,975	37,824	68.00
69.00	06900	ELECTROCARDIOLOGY	0.047346	57,870	2,740	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.124697	3,897	486	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.064443	59,951	63,814	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.514547	13,464	6,928	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.257738	484,772	124,944	73.00
73.01	07301	OUTPATIENT PHARMACY	0.000000	0	0	73.01
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
76.00	03950	LITHOTRIPSY	0.000000	0	0	76.00
76.01	03951	CARDIAC REHABILITATION	0.278584	0	0	76.01
76.02	03020	GASTROINTESTINAL SERVICES	0.137989	426	59	76.02
76.03	03030	ANGIOCARDIOGRAPHY	0.000000	0	0	76.03
76.05	03954	INPATIENT RENAL DIALYSIS	0.000000	0	0	76.05
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.004671	0	0	90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES	0.000000	0	0	90.01
90.02	04950	WOUND CARE	0.275520	0	0	90.02
90.03	09003	RIVER FOREST	0.000000	0	0	90.03
91.00	09100	EMERGENCY	0.104809	5,716	599	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.279317	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		3,132,905	574,290	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)		3,132,905		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-0008 | Component CCN: 14-5526 | Period: From 07/01/2017 To 06/30/2018 | Worksheet D-3 | Date/Time Prepared: 11/29/2018 6:55 pm

Title XVIII | Skilled Nursing Facility | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.384569	46,066	17,716	50.00
51.00	05100	RECOVERY ROOM	0.085613	19	2	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.007434	40,004	297	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.161927	112,279	18,181	54.00
56.00	05600	RADIOISOTOPE	0.075937	10,757	817	56.00
56.01	03630	ULTRASOUND	0.074966	106,530	7,986	56.01
57.00	05700	CT SCAN	0.020300	92,138	1,870	57.00
58.00	05800	MRI	0.040742	8,523	347	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.099105	43,403	4,301	59.00
60.00	06000	LABORATORY	0.113732	835,379	95,009	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.117176	975,679	114,326	65.00
66.00	06600	PHYSICAL THERAPY	0.193083	821,759	158,668	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.219065	376,104	82,391	67.00
68.00	06800	SPEECH PATHOLOGY	0.343930	153,653	52,846	68.00
69.00	06900	ELECTROCARDIOLOGY	0.047346	100,588	4,762	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.124697	6,495	810	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.064443	235,422	250,593	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.514547	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.257738	704,034	181,456	73.00
73.01	07301	OUTPATIENT PHARMACY	0.000000	0	0	73.01
74.00	07400	RENAL DIALYSIS	0.000000	0	0	74.00
76.00	03950	LITHOTRIPSY	0.000000	0	0	76.00
76.01	03951	CARDIAC REHABILITATION	0.278584	0	0	76.01
76.02	03020	GASTROINTESTINAL SERVICES	0.137989	36,007	4,969	76.02
76.03	03030	ANGIOCARDIOGRAPHY	0.000000	0	0	76.03
76.05	03954	INPATIENT RENAL DIALYSIS	0.000000	0	0	76.05
76.97	07697	CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	0	76.99
		OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.004671	0	0	90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES	0.000000	0	0	90.01
90.02	04950	WOUND CARE	0.275520	437	120	90.02
90.03	09003	RIVER FOREST	0.000000	0	0	90.03
91.00	09100	EMERGENCY	0.104809	7,094	744	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.279317	0	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		4,712,370	998,211	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)		4,712,370		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 14-0008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet E Part A Date/Time Prepared: 11/29/2018 6:55 pm

Title XVIII | Hospital | PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	22,470,212	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	0	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1.04
2.00	Outlier payments for discharges. (see instructions)	81,681	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
3.00	Managed Care Simulated Payments	7,369,150	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	156.85	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	3.30	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.57	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	2.73	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	3.27	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.05	11.00
12.00	Current year allowable FTE (see instructions)	2.78	12.00
13.00	Total allowable FTE count for the prior year.	1.97	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.	2.02	14.00
15.00	Sum of lines 12 through 14 divided by 3.	2.26	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	2.26	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.014409	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.012510	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.012510	21.00
22.00	IME payment adjustment (see instructions)	153,134	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	50,221	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.54	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)	153,134	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	50,221	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	3.44	30.00
31.00	Percentage of Medicaid patient days (see instructions)	13.28	31.00
32.00	Sum of lines 30 and 31	16.72	32.00
33.00	Allowable disproportionate share percentage (see instructions)	3.62	33.00
34.00	Disproportionate share adjustment (see instructions)	203,356	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 14-0008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet E Part A Date/Time Prepared: 11/29/2018 6:55 pm

Title XVIII | Hospital | PPS

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	0	0	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	1,107,890	1,083,320	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	279,249	810,264	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,089,513		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 an 685. (see instructions)	0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 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 an 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)	23,997,896		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)		24,048,117	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		1,860,144	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).		67,009	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		1,036	54.00
54.01	Islet isolation add-on payment		0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		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)		25,976,306	59.00
60.00	Primary payer payments		0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		25,976,306	61.00
62.00	Deductibles billed to program beneficiaries		2,286,720	62.00
63.00	Coinsurance billed to program beneficiaries		128,279	63.00
64.00	Allowable bad debts (see instructions)		428,308	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		278,400	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		204,487	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		23,839,707	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)		0	70.50
70.87	Demonstration payment adjustment amount before sequestration		0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)			70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		-35,581	70.93
70.94	HRR adjustment amount (see instructions)		-55,729	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0008	Period: From 07/01/2017 To 06/30/2018	Worksheet E Part A Date/Time Prepared: 11/29/2018 6:55 pm
	Title XVIII	Hospital	PPS

		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		23,748,397	71.00
71.01	Sequestration adjustment (see instructions)		474,968	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		23,337,457	72.00
73.00	Tentative settlement (for contractor use only)		0	73.00
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		-64,028	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		1,435,080	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	HSP Bonus Payment Amount			
100.00	HSP bonus amount (see instructions)	0	0	100.00
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)	0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102.00
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)	0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104.00
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
	Adjustment to Medicare Part A Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (see instructions)			211.00
	Comparision 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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0008	Period: From 07/01/2017 To 06/30/2018	Worksheet E Part B Date/Time Prepared: 11/29/2018 6:55 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	7,339	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	8,695,854	2.00
3.00	OPPS payments	9,551,102	3.00
4.00	Outlier payment (see instructions)	4,942	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)	7,339	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	25,545	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)	25,545	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)	25,545	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	18,206	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)	7,339	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	9,556,044	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	1,699	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,878,068	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	7,683,616	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	14,703	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	7,698,319	30.00
31.00	Primary payer payments	3,094	31.00
32.00	Subtotal (line 30 minus line 31)	7,695,225	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)	251,566	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	163,518	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	112,444	36.00
37.00	Subtotal (see instructions)	7,858,743	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)	7,858,743	40.00
40.01	Sequestration adjustment (see instructions)	157,175	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	7,813,055	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	-111,487	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	90,430	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: 14-0008 Component CCN: 14-S008	Period: From 07/01/2017 To 06/30/2018	Worksheet E Part B Date/Time Prepared: 11/29/2018 6:55 pm
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	0	2.00
3.00	OPPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	0	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	0	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance 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
41.00	Interim payments	0	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	0	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	8,423	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: 14-0008 Component CCN: 14-T008	Period: From 07/01/2017 To 06/30/2018	Worksheet E Part B Date/Time Prepared: 11/29/2018 6:55 pm
	Title XVIII	Subprovider - IRF	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)	317	2.00
3.00	OPPS payments	64	3.00
4.00	Outlier payment (see instructions)	0	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	0	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	0	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	64	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	13	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)	51	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)	51	30.00
31.00	Primary payer payments	0	31.00
32.00	Subtotal (line 30 minus line 31)	51	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)	51	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)	51	40.00
40.01	Sequestration adjustment (see instructions)	1	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	50	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	0	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	1,283	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: 14-0008 Component CCN: 14-5526	Period: From 07/01/2017 To 06/30/2018	Worksheet E Part B Date/Time Prepared: 11/29/2018 6:55 pm
	Title XVIII	Skilled Nursing Facility	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		3.00
4.00	Outlier payment (see instructions)		4.00
4.01	Outlier reconciliation amount (see instructions)		4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)		5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	0	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	0	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0	20.00
21.00	Lesser of cost or charges (see instructions)	0	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		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		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
41.00	Interim payments	0	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	0	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	6,306	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)		90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		91.00
92.00	The rate used to calculate the Time Value of Money		92.00
93.00	Time Value of Money (see instructions)		93.00
94.00	Total (sum of lines 91 and 93)		94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet E-1 Part I | Date/Time Prepared: 11/29/2018 6:55 pm

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		23,337,457		7,813,055	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)		23,337,457		7,813,055	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		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		64,028		111,487	6.02
7.00	Total Medicare program liability (see instructions)		23,273,429		7,701,568	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0008 | Component CCN: 14-S008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet E-1 Part I | Date/Time Prepared: 11/29/2018 6:55 pm

Title XVIII | Subprovider - IPF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		2,820,460		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)		2,820,460		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		17,355		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,837,815		0	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0008 | Component CCN: 14-T008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet E-1 Part I | Date/Time Prepared: 11/29/2018 6:55 pm

Title XVIII | Subprovider - IRF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		4,566,570		50	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)		4,566,570		50	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		97,525		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		4,664,095		50	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0008 | Component CCN: 14-5526 | Period: From 07/01/2017 To 06/30/2018 | Worksheet E-1 Part I | Date/Time Prepared: 11/29/2018 6:55 pm

Title XVIII | Skilled Nursing Facility | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		3,458,259		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)		3,458,259		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		6,180		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		3,464,439		0	7.00

			Contractor Number	NPR Date (Mo/Day/Yr)	
		0	1.00	2.00	
8.00	Name of Contractor				8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 14-0008	Period: From 07/01/2017 To 06/30/2018	Worksheet E-1 Part II Date/Time Prepared: 11/29/2018 6:55 pm
	Title XVIII	Hospital	PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0008 Component CCN: 14-S008	Period: From 07/01/2017 To 06/30/2018	Worksheet E-3 Part II Date/Time Prepared: 11/29/2018 6:55 pm
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS		
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	3,025,971	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 instuctions)	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 instuctions)	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)	9.257534	9.00
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).	0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	3,025,971	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)		14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)	0	15.00
16.00	Subtotal (see instructions)	3,025,971	16.00
17.00	Primary payer payments	0	17.00
18.00	Subtotal (line 16 less line 17).	3,025,971	18.00
19.00	Deductibles	132,680	19.00
20.00	Subtotal (line 18 minus line 19)	2,893,291	20.00
21.00	Coinsurance	15,266	21.00
22.00	Subtotal (line 20 minus line 21)	2,878,025	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	27,238	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	17,705	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	14,280	25.00
26.00	Subtotal (sum of lines 22 and 24)	2,895,730	26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	27.00
28.00	Other pass through costs (see instructions)	0	28.00
29.00	Outlier payments reconciliation	0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	30.50
30.99	Demonstration payment adjustment amount before sequestration	0	30.99
31.00	Total amount payable to the provider (see instructions)	2,895,730	31.00
31.01	Sequestration adjustment (see instructions)	57,915	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	31.02
32.00	Interim payments	2,820,460	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)	17,355	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	8,423	35.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	0	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0008 Component CCN: 14-T008	Period: From 07/01/2017 To 06/30/2018	Worksheet E-3 Part III Date/Time Prepared: 11/29/2018 6:55 pm
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	4,429,346	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0284	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	181,160	3.00
4.00	Outlier Payments	218,612	4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0.00	5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	5.01
6.00	New Teaching program adjustment. (see instructions)	0.00	6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)	0.00	7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)	0.00	8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9.00
10.00	Average Daily Census (see instructions)	15.095890	10.00
11.00	Teaching Adjustment Factor (see instructions)	0.000000	11.00
12.00	Teaching Adjustment (see instructions)	0	12.00
13.00	Total PPS Payment (see instructions)	4,829,118	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)	0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)		15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)	0	16.00
17.00	Subtotal (see instructions)	4,829,118	17.00
18.00	Primary payer payments	0	18.00
19.00	Subtotal (line 17 less line 18).	4,829,118	19.00
20.00	Deductibles	26,488	20.00
21.00	Subtotal (line 19 minus line 20)	4,802,630	21.00
22.00	Coinsurance	44,632	22.00
23.00	Subtotal (line 21 minus line 22)	4,757,998	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	1,974	24.00
25.00	Adjusted reimbursable bad debts (see instructions)	1,283	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	26.00
27.00	Subtotal (sum of lines 23 and 25)	4,759,281	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28.00
29.00	Other pass through costs (see instructions)	0	29.00
30.00	Outlier payments reconciliation	0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	31.50
31.99	Demonstration payment adjustment amount before sequestration	0	31.99
32.00	Total amount payable to the provider (see instructions)	4,759,281	32.00
32.01	Sequestration adjustment (see instructions)	95,186	32.01
32.02	Demonstration payment adjustment amount after sequestration	0	32.02
33.00	Interim payments	4,566,570	33.00
34.00	Tentative settlement (for contractor use only)	0	34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)	97,525	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	1,283	36.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	218,612	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0008 Component CCN: 14-5526	Period: From 07/01/2017 To 06/30/2018	Worksheet E-3 Part VI Date/Time Prepared: 11/29/2018 6:55 pm
	Title XVIII	Skilled Nursing Facility	PPS

		1.00	
	PART VI - CALCULATION OF REIMBURSEMENT SETTLEMEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES		
	PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)		
1.00	Resource Utilization Group Payment (RUGS)	3,693,881	1.00
2.00	Routine service other pass through costs	0	2.00
3.00	Ancillary service other pass through costs	0	3.00
4.00	Subtotal (sum of lines 1 through 3)	3,693,881	4.00
	COMPUTATION OF NET COST OF COVERED SERVICES		
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)		5.00
6.00	Deductible	0	6.00
7.00	Coinsurance	165,045	7.00
8.00	Allowable bad debts (see instructions)	9,701	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)	6,306	10.00
11.00	Utilization review	0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)	3,535,142	12.00
13.00	Inpatient primary payer payments	0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	14.50
14.99	Demonstration payment adjustment amount before sequestration	0	14.99
15.00	Subtotal (see instructions	3,535,142	15.00
15.01	Sequestration adjustment (see instructions)	70,703	15.01
15.02	Demonstration payment adjustment amount after sequestration	0	15.02
16.00	Interim payments	3,458,259	16.00
17.00	Tentative settlement (for contractor use only)	0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 15.02, 16, and 17)	6,180	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2	6,306	19.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS | Provider CCN: 14-0008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet E-4 | Date/Time Prepared: 11/29/2018 6:55 pm

Title XVIII | Hospital | PPS

				1.00	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT				
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			1.54	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.23	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts			1.31	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			3.27	6.00
7.00	Enter the lesser of line 5 or line 6			1.31	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	0.00	2.76	2.76	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	1.11	1.11	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		0.05		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	1.16		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.47	0.84		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.62	0.72		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	0.36	0.91		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00		15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00		16.01
17.00	Adjusted rolling average FTE count	0.36	0.91		17.00
18.00	Per resident amount	95,779.85	95,779.85		18.00
19.00	Approved amount for resident costs	34,481	87,160	121,641	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			1.96	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locality adjustment national average per resident amount (see instructions)			0.00	23.00
24.00	Multiply line 22 time line 23			0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			121,641	25.00
		Inpatient Part A	Managed care		
		1.00	2.00	3.00	
	COMPUTATION OF PROGRAM PATIENT LOAD				
26.00	Inpatient Days (see instructions)	17,409	4,656		26.00
27.00	Total Inpatient Days (see instructions)	31,868	31,868		27.00
28.00	Ratio of inpatient days to total inpatient days	0.546285	0.146103		28.00
29.00	Program direct GME amount	66,451	17,772		29.00
30.00	Reduction for direct GME payments for Medicare Advantage		2,511		30.00
31.00	Net Program direct GME amount			81,712	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS	Provider CCN: 14-0008	Period: From 07/01/2017 To 06/30/2018	Worksheet E-4 Date/Time Prepared: 11/29/2018 6:55 pm
	Title XVIII	Hospital	PPS

		1.00	
	DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)		
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)	0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)	0	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)	0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)	0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)	0	36.00
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY		
	Part A Reasonable Cost		
37.00	Reasonable cost (see instructions)	39,650,730	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)	39,650,730	41.00
	Part B Reasonable Cost		
42.00	Reasonable cost (see instructions)	8,703,510	42.00
43.00	Primary payer payments (see instructions)	3,094	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)	8,700,416	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)	48,351,146	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)	0.820058	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)	0.179942	47.00
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B		
48.00	Total program GME payment (line 31)	81,712	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)	67,009	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)	14,703	50.00

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

Provider CCN: 14-0008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet G | Date/Time Prepared: 11/29/2018 6:55 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	-1,363,530	0	0	0	1.00
2.00	Temporary investments	56,530,573	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	22,667,934	0	0	0	4.00
5.00	Other receivable	67,325,626	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-10,887,796	0	0	0	6.00
7.00	Inventory	3,127,000	0	0	0	7.00
8.00	Prepaid expenses	584,767	0	0	0	8.00
9.00	Other current assets	14,971,325	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)	152,955,899	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	12,500,000	0	0	0	12.00
13.00	Land improvements	1,244,408	0	0	0	13.00
14.00	Accumulated depreciation	-405,667	0	0	0	14.00
15.00	Buildings	70,687,742	0	0	0	15.00
16.00	Accumulated depreciation	-27,821,965	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	46,829,553	0	0	0	23.00
24.00	Accumulated depreciation	-29,447,745	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)	73,586,326	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	7,011,745	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	7,011,745	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	233,553,970	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	87,768,223	0	0	0	37.00
38.00	Salaries, wages, and fees payable	3,764,507	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	10,857,693	0	0	0	43.00
44.00	Other current liabilities	445,888	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	102,836,311	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	19,209,264	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	19,209,264	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	122,045,575	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	111,508,395				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	111,508,395	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	233,553,970	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-0008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet G-1 | Date/Time Prepared: 11/29/2018 6:55 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		108,800,228		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		2,708,167				2.00
3.00	Total (sum of line 1 and line 2)		111,508,395		0		3.00
4.00	Additions (credit adjustments) (specify)	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0		0		10.00
11.00	Subtotal (line 3 plus line 10)		111,508,395		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		111,508,395		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 14-0008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet G-2 Parts I & II | Date/Time Prepared: 11/29/2018 6:55 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	63,994,039		63,994,039	1.00
2.00	SUBPROVIDER - IPF	8,836,744		8,836,744	2.00
3.00	SUBPROVIDER - IRF	11,652,591		11,652,591	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	18,029,790		18,029,790	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)	102,513,164		102,513,164	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	15,566,770		15,566,770	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	15,566,770		15,566,770	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	118,079,934		118,079,934	17.00
18.00	Ancillary services	178,137,721	0	178,137,721	18.00
19.00	Outpatient services	0	254,728,174	254,728,174	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
24.20	OUTPATIENT PHYSICAL THERAPY	0	0	0	24.20
24.30	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	24.30
24.40	OUTPATIENT SPEECH PATHOLOGY	0	0	0	24.40
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER	0	0	0	27.00
27.02	Intern-Resident Service (not appvd. tchng. prgm.)	0	1,505,771	1,505,771	27.02
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	296,217,655	256,233,945	552,451,600	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		120,152,308		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		120,152,308		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 14-0008 | Period: From 07/01/2017 To 06/30/2018 | Worksheet G-3 | Date/Time Prepared: 11/29/2018 6:55 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	552,451,600	1.00
2.00	Less contractual allowances and discounts on patients' accounts	438,043,458	2.00
3.00	Net patient revenues (line 1 minus line 2)	114,408,142	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	120,152,308	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-5,744,166	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	29,977	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	1,800,310	22.00
23.00	Governmental appropriations	0	23.00
24.00	DAY CARE	1,487,346	24.00
24.01	MEDICARE EHR INCENTIVE PAYMENTS	0	24.01
24.02	REFERENCE LAB	1,999,205	24.02
24.04	OTHER INCOME	3,135,495	24.04
25.00	Total other income (sum of lines 6-24)	8,452,333	25.00
26.00	Total (line 5 plus line 25)	2,708,167	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)	2,708,167	29.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 14-0008	Period: From 07/01/2017 To 06/30/2018	Worksheet L Parts I-III Date/Time Prepared: 11/29/2018 6:55 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	1,827,589	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	13,914	2.00
2.01	Model 4 BPCI Capital DRG outlier payments	0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)	63.42	3.00
4.00	Number of interns & residents (see instructions)	2.26	4.00
5.00	Indirect medical education percentage (see instructions)	1.02	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)	18,641	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)	1,860,144	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