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: 14-0213	Period: From 10/01/2017 To 09/30/2018	Worksheet S Parts I-III Date/Time Prepared: 2/25/2019 3:00 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 2/25/2019 Time: 3:00 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 SILVER CROSS HOSPITAL (14-0213) for the cost reporting period beginning 10/01/2017 and ending 09/30/2018 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	-40,102	219,833	0	0	1.00
2.00	Subprovider - IPF	0	50,170	0		0	2.00
3.00	Subprovider - IRF	0	-8,057	0		0	3.00
4.00	SUBPROVIDER I						4.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
8.00	NURSING FACILITY	0				0	8.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
12.00	CMHC I	0		0		0	12.00
200.00	Total	0	2,011	219,833	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-2 Part I Date/Time Prepared: 2/25/2019 3:00 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1900 SILVER CROSS BLVD.	PO Box:			1.00
2.00	City: NEW LENOX	State: IL	Zip Code: 60451	County: WILL	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	SILVER CROSS HOSPITAL	140213	16974	1	07/01/1966	N	P	P	3.00
4.00	Subprovider - IPF	SCH - MENTAL HEALTH CARE UNIT	14S213	16974	4	04/01/1991	N	P	P	4.00
5.00	Subprovider - IRF	SCH - REHAB	14T213	16974	5	10/01/2000	N	P	P	5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	SCH HOME HEALTH	147452	16974		04/01/1994	N	P	N	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
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)	10/01/2017	09/30/2018	20.00
21.00	Type of Control (see instructions)	1		21.00

		1.00	2.00	3.00	
	Inpatient PPS Information				
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	Y		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	1	N		23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	2,403	2,746	0	0	4,751	0	24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-2 Part I Date/Time Prepared: 2/25/2019 3:00 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.	0	96	0	0	45		25.00

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

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

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

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	Y	N	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.	N			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.				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)	Y			60.00
60.01	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		23.00	1	60.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-2 Part I | Date/Time Prepared: 2/25/2019 3:00 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: 14-0213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-2 Part I Date/Time Prepared: 2/25/2019 3:00 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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-2 Part I | Date/Time Prepared: 2/25/2019 3:00 pm

		1.00	2.00	3.00	
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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-2 Part I Date/Time Prepared: 2/25/2019 3:00 pm

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

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

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

		1.00	2.00	3.00	
	Miscellaneous Cost Reporting Information				
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	0			118.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-0213	Period: From 10/01/2017 To 09/30/2018	Worksheet S-2 Part I Date/Time Prepared: 2/25/2019 3:00 pm

		1.00	2.00	
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		140.00

	1.00	2.00	3.00	
	If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.			
141.00	Name:	Contractor's Name:	Contractor's Number:	141.00
142.00	Street:	PO Box:		142.00
143.00	City:	State:	Zip Code:	143.00

		1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	Y	144.00

		1.00	2.00	
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	Y		145.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00

		1.00	
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N	149.00

		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
	Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N	155.00
156.00	Subprovider - IPF	N	N	N	N	156.00
157.00	Subprovider - IRF	N	N	N	N	157.00
158.00	SUBPROVIDER					158.00
159.00	SNF	N	N	N	N	159.00
160.00	HOME HEALTH AGENCY	N	N	N	N	160.00
161.00	CMHC		N	N	N	161.00
161.10	CORF		N	N	N	161.10

		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)	10/01/2017	09/30/2018	170.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-0213	Period: From 10/01/2017 To 09/30/2018	Worksheet S-2 Part I Date/Time Prepared: 2/25/2019 3:00 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: 14-0213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-2 Part II | Date/Time Prepared: 2/25/2019 3:00 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		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.	Y		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N		8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

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

		Part A		Part B		
		Y/N	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	01/25/2019	Y	01/25/2019	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: 14-0213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-2 Part II Date/Time Prepared: 2/25/2019 3:00 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	N	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.	N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N	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.	N	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	N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N	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.	N	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.	Y	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.	N	35.00

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

		1.00	2.00	
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	VINCE	PRYOR	41.00
42.00	Enter the employer/company name of the cost report preparer.	SILVER CROSS HOSPITAL		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	815-300-7011	VPRYOR@SILVERCROSS.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-0213	Period: From 10/01/2017 To 09/30/2018	Worksheet S-2 Part II Date/Time Prepared: 2/25/2019 3:00 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.	SENIOR VICE PRESIDENT & CFO		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-0213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-3 Part I Date/Time Prepared: 2/25/2019 3:00 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	229	83,585	0.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		229	83,585	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	28	10,220	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)		257	93,805	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	20	7,300		0	16.00
17.00	SUBPROVIDER - IRF	41.00	25	9,125		0	17.00
18.00	SUBPROVIDER	42.00	0	0		0	18.00
19.00	SKILLED NURSING FACILITY	44.00	0	0		0	19.00
20.00	NURSING FACILITY	45.00	0	0		0	20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC	99.00				0	25.00
25.10	CMHC - CORF	99.10				0	25.10
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		302				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-0213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-3 Part I | Date/Time Prepared: 2/25/2019 3:00 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)	25,441	3,760	55,864			1.00
2.00	HMO and other (see instructions)	7,484	4,751				2.00
3.00	HMO IPF Subprovider	7	972				3.00
4.00	HMO IRF Subprovider	566	45				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	25,441	3,760	55,864			7.00
8.00	INTENSIVE CARE UNIT	3,266	522	7,381			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		465	6,959			13.00
14.00	Total (see instructions)	28,707	4,747	70,204	0.00	1,759.16	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	989	708	5,739	0.00	28.72	16.00
17.00	SUBPROVIDER - IRF	5,757	96	8,099	0.00	52.40	17.00
18.00	SUBPROVIDER		0	0	0.00	0.00	18.00
19.00	SKILLED NURSING FACILITY	0	0	0	0.00	0.00	19.00
20.00	NURSING FACILITY		0	0	0.00	0.00	20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	17,277	0	24,429	0.00	22.99	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)			0			24.10
25.00	CMHC - CMHC	0	0	0	0.00	0.00	25.00
25.10	CMHC - CORF	0	0	0	0.00	0.00	25.10
26.00	RURAL HEALTH CLINIC	0	0	0	0.00	0.00	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00	Total (sum of lines 14-26)				0.00	1,863.27	27.00
28.00	Observation Bed Days		1,715	11,758			28.00
29.00	Ambulance Trips	0					29.00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31.00
32.00	Labor & delivery days (see instructions)	0	402	1,705			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-0213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-3 Part I | Date/Time Prepared: 2/25/2019 3:00 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	7,033	1,684	15,848	1.00
2.00	HMO and other (see instructions)			1,761	1,546		2.00
3.00	HMO IPF Subprovider				168		3.00
4.00	HMO IRF Subprovider				5		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	7,033	1,684	15,848	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	137	113	979	16.00
17.00	SUBPROVIDER - IRF	0.00	0	445	9	648	17.00
18.00	SUBPROVIDER	0.00	0		0	0	18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY	0.00					20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC	0.00					25.00
25.10	CMHC - CORF	0.00					25.10
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-3 Part II Date/Time Prepared: 2/25/2019 3:00 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	127,586,467	0	127,586,467	3,875,606.40	32.92	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	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		8,021,393	0	8,021,393	229,252.00	34.99	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		2,342,336	0	2,342,336	71,197.74	32.90	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		516,373	0	516,373	4,109.50	125.65	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		6,052,479	0	6,052,479	16,885.40	358.44	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)		30,328,111	0	30,328,111			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		2,034,655	0	2,034,655			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)		0	0	0			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

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-3 Part II | Date/Time Prepared: 2/25/2019 3:00 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	
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	1,087,243	0	1,087,243	28,139.20	38.64	26.00
27.00	Administrative & General	5.00	18,417,623	-418,788	17,998,835	536,154.43	33.57	27.00
28.00	Administrative & General under contract (see inst.)		398,806	0	398,806	8,061.55	49.47	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	3,113,341	0	3,113,341	121,716.80	25.58	30.00
31.00	Laundry & Linen Service	8.00	67,221	0	67,221	4,230.40	15.89	31.00
32.00	Housekeeping	9.00	2,457,617	0	2,457,617	162,292.00	15.14	32.00
33.00	Housekeeping under contract (see instructions)		97,948	0	97,948	9,052.40	10.82	33.00
34.00	Dietary	10.00	2,385,013	-1,810,046	574,967	35,943.70	16.00	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	1,810,046	1,810,046	113,153.90	16.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	2,759,657	0	2,759,657	64,071.20	43.07	38.00
39.00	Central Services and Supply	14.00	1,652,801	-989,918	662,883	39,032.00	16.98	39.00
40.00	Pharmacy	15.00	3,551,528	0	3,551,528	73,298.40	48.45	40.00
41.00	Medical Records & Medical Records Library	16.00	2,818,593	0	2,818,593	97,521.60	28.90	41.00
42.00	Social Service	17.00	0	418,788	418,788	13,466.37	31.10	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-3 Part III Date/Time Prepared: 2/25/2019 3:00 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)		128,083,221	0	128,083,221	3,892,720.35	32.90	1.00
2.00	Excluded area salaries (see instructions)		8,021,393	0	8,021,393	229,252.00	34.99	2.00
3.00	Subtotal salaries (line 1 minus line 2)		120,061,828	0	120,061,828	3,663,468.35	32.77	3.00
4.00	Subtotal other wages & related costs (see inst.)		8,911,188	0	8,911,188	92,192.64	96.66	4.00
5.00	Subtotal wage-related costs (see inst.)		30,328,111	0	30,328,111	0.00	25.26	5.00
6.00	Total (sum of lines 3 thru 5)		159,301,127	0	159,301,127	3,755,660.99	42.42	6.00
7.00	Total overhead cost (see instructions)		38,807,391	-989,918	37,817,473	1,306,133.95	28.95	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 14-0213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-3 Part IV Date/Time Prepared: 2/25/2019 3:00 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	5,675,156	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	0	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	8,498,179	8.02
8.03	Health Insurance (Purchased)	4,837,281	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	721,449	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	140,598	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)	668,000	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	1,974,694	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	9,440,062	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	100,000	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	307,347	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	32,362,766	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: 14-0213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-3 Part V Date/Time Prepared: 2/25/2019 3:00 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	2,342,336	32,362,766	1.00
2.00	Hospital	2,342,336	32,362,766	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	0	0	8.00
9.00	Hospital-Based NF	0	0	9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
15.00	Hospital-Based Health Clinic FQHC	0	0	15.00
16.00	Hospital-Based-CMHC	0	0	16.00
16.10	Hospital-Based-CMHC 10	0	0	16.10
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

HOME HEALTH AGENCY STATISTICAL DATA | Provider CCN: 14-0213 | Component CCN: 14-7452 | Period: From 10/01/2017 To 09/30/2018 | Worksheet S-4 | Date/Time Prepared: 2/25/2019 3:00 pm

Home Health Agency I | PPS

					1.00		
0.00	County						0.00
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
	HOME HEALTH AGENCY STATISTICAL DATA						
1.00	Home Health Aide Hours	0	2,074	2	342	2,418	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	720.00	16.00	684.00	1,420.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES						
3.00	Administrator and Assistant Administrator(s)		0.00	7.81	0.00	7.81	3.00
4.00	Director(s) and Assistant Director(s)			0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel			0.00	0.00	0.00	5.00
6.00	Direct Nursing Service			14.14	0.00	14.14	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			0.00	6.93	6.93	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			0.00	0.00	0.00	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.00	0.00	0.00	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.03	0.00	0.03	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			1.16	0.24	1.40	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	Other (specify)			0.00	0.00	0.00	18.00
	HOME HEALTH AGENCY CBSA CODES						
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			1			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			16974			20.00
		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	6,300	1,219	203	570	8,292	21.00
22.00	Skilled Nursing Visit Charges	1,517,040	293,535	48,160	133,403	1,992,138	22.00
23.00	Physical Therapy Visits	4,338	691	23	309	5,361	23.00
24.00	Physical Therapy Visit Charges	979,520	156,028	5,193	68,643	1,209,384	24.00
25.00	Occupational Therapy Visits	1,678	312	3	148	2,141	25.00
26.00	Occupational Therapy Visit Charges	378,892	70,450	677	32,741	482,760	26.00
27.00	Speech Pathology Visits	190	63	2	23	278	27.00
28.00	Speech Pathology Visit Charges	45,534	15,098	479	5,512	66,623	28.00
29.00	Medical Social Service Visits	77	28	0	5	110	29.00
30.00	Medical Social Service Visit Charges	25,391	9,233	0	1,649	36,273	30.00
31.00	Home Health Aide Visits	646	391	1	57	1,095	31.00
32.00	Home Health Aide Visit Charges	95,124	57,575	147	8,393	161,239	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	13,229	2,704	232	1,112	17,277	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	3,041,501	601,919	54,656	250,341	3,948,417	35.00
36.00	Total Number of Episodes (standard/non outlier)	717		75	48	840	36.00
37.00	Total Number of Outlier Episodes		66		16	82	37.00
38.00	Total Non-Routine Medical Supply Charges	9,760	6,259	2,033	2,458	20,510	38.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 14-0213	Period: From 10/01/2017 To 09/30/2018	Worksheet S-10 Date/Time Prepared: 2/25/2019 3:00 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)	0.266980	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	31,770,262	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?	Y	3.00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	115,884,341	6.00
7.00	Medicaid cost (line 1 times line 6)	30,938,801	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)	0	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)	0	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)	16,414,098	6,206,953	22,621,051	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	4,382,236	6,206,953	10,589,189	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	4,382,236	6,206,953	10,589,189	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	14,675,298	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	1,089,746	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	1,676,533	27.01
28.00	Non-Medicare bad debt expense (see instructions)	12,998,765	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	4,057,197	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	14,646,386	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	14,646,386	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet A | Date/Time Prepared: 2/25/2019 3:00 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		57,224,573	57,224,573	-23,212,965	34,011,608	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	17,056,197	17,056,197	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	1,087,243	33,433,114	34,520,357	0	34,520,357	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	18,417,623	48,694,693	67,112,316	1,698,777	68,811,093	5.00
7.00	00700	OPERATION OF PLANT	3,113,341	6,637,460	9,750,801	0	9,750,801	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	67,221	25,764	92,985	0	92,985	8.00
9.00	00900	HOUSEKEEPING	2,457,617	1,488,397	3,946,014	0	3,946,014	9.00
10.00	01000	DIETARY	2,385,013	2,743,956	5,128,969	-3,892,503	1,236,466	10.00
11.00	01100	CAFETERIA	0	0	0	3,892,503	3,892,503	11.00
13.00	01300	NURSING ADMINISTRATION	2,759,657	47,769	2,807,426	-22	2,807,404	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,652,801	2,114,510	3,767,311	-2,584,146	1,183,165	14.00
15.00	01500	PHARMACY	3,551,528	14,730,599	18,282,127	-12,660,828	5,621,299	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,818,593	1,074,878	3,893,471	0	3,893,471	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	418,788	418,788	17.00
23.00	02300	PARAMED ED PRGM	392,318	387,924	780,242	-1,393	778,849	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	23,071,801	3,485,945	26,557,746	4,884,044	31,441,790	30.00
31.00	03100	INTENSIVE CARE UNIT	6,012,351	1,204,542	7,216,893	455,151	7,672,044	31.00
40.00	04000	SUBPROVIDER - IPF	1,900,025	416,002	2,316,027	378,559	2,694,586	40.00
41.00	04100	SUBPROVIDER - IRF	3,810,184	608,189	4,418,373	93,039	4,511,412	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	8,968,052	597,744	9,565,796	-7,379,284	2,186,512	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,866,899	35,780,901	45,647,800	-23,904,050	21,743,750	50.00
51.00	05100	RECOVERY ROOM	1,378,815	90,272	1,469,087	-736	1,468,351	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	824,407	824,407	3,556,343	4,380,750	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,548,685	14,452,807	23,001,492	-9,206,094	13,795,398	54.00
54.01	05401	ULTRASOUND	1,203,237	363,328	1,566,565	-7,418	1,559,147	54.01
57.00	05700	CT SCAN	1,240,431	1,080,015	2,320,446	-16,894	2,303,552	57.00
58.00	05800	MRI	686,892	574,354	1,261,246	0	1,261,246	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	4,007,811	7,033,868	11,041,679	51,874	11,093,553	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	266,725	1,747,704	2,014,429	0	2,014,429	63.00
65.00	06500	RESPIRATORY THERAPY	1,821,748	341,115	2,162,863	83,370	2,246,233	65.00
65.01	06501	SLEEP LAB	249,313	173,881	423,194	110,000	533,194	65.01
66.00	06600	PHYSICAL THERAPY	1,401,590	376,832	1,778,422	-446	1,777,976	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,795,950	405,049	2,200,999	-4,723	2,196,276	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,372,100	195,358	1,567,458	144,725	1,712,183	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	134,165	26,682	160,847	823,245	984,092	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	14,624,932	14,624,932	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	21,713,491	21,713,491	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	12,612,722	12,612,722	73.00
74.00	07400	RENAL DIALYSIS	410,764	147,204	557,968	11,491	569,459	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	545,874	207,339	753,213	8,486	761,699	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	7,500,925	2,936,401	10,437,326	309,530	10,746,856	91.00
91.01	09101	OP MENTAL HEALTH	470,792	10,688	481,480	0	481,480	91.01
91.02	09102	DIABETES CENTER	299,517	3,278	302,795	-76,543	226,252	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	1,903,898	1,183,665	3,087,563	20,778	3,108,341	101.00
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	127,571,499	242,871,207	370,442,706	0	370,442,706	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	14,968	0	14,968	0	14,968	190.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet A | Date/Time Prepared: 2/25/2019 3:00 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	
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		TOTAL (SUM OF LINES 118 through 199)	127,586,467	242,871,207	370,457,674	0	370,457,674	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet A | Date/Time Prepared: 2/25/2019 3:00 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	-11,596,307	22,415,301		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	17,056,197		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-69,785	34,450,572		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-19,804,257	49,006,836		5.00
7.00	00700	OPERATION OF PLANT	-3,315	9,747,486		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	92,985		8.00
9.00	00900	HOUSEKEEPING	0	3,946,014		9.00
10.00	01000	DIETARY	0	1,236,466		10.00
11.00	01100	CAFETERIA	-2,398,261	1,494,242		11.00
13.00	01300	NURSING ADMINISTRATION	0	2,807,404		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-1,282	1,181,883		14.00
15.00	01500	PHARMACY	-4,200	5,617,099		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-739	3,892,732		16.00
17.00	01700	SOCIAL SERVICE	0	418,788		17.00
23.00	02300	PARAMED ED PRGM	-157,022	621,827		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-1,471,772	29,970,018		30.00
31.00	03100	INTENSIVE CARE UNIT	-674,437	6,997,607		31.00
40.00	04000	SUBPROVIDER - IPF	-373,460	2,321,126		40.00
41.00	04100	SUBPROVIDER - IRF	-110,790	4,400,622		41.00
42.00	04200	SUBPROVIDER	0	0		42.00
43.00	04300	NURSERY	-4,835	2,181,677		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0		44.00
45.00	04500	NURSING FACILITY	0	0		45.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-69	21,743,681		50.00
51.00	05100	RECOVERY ROOM	0	1,468,351		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	4,380,750		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,945,692	15,741,090		54.00
54.01	05401	ULTRASOUND	0	1,559,147		54.01
57.00	05700	CT SCAN	0	2,303,552		57.00
58.00	05800	MRI	0	1,261,246		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	-1,248	11,092,305		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	2,014,429		63.00
65.00	06500	RESPIRATORY THERAPY	-88,332	2,157,901		65.00
65.01	06501	SLEEP LAB	-110,000	423,194		65.01
66.00	06600	PHYSICAL THERAPY	0	1,777,976		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,196,276		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	-161,477	1,550,706		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	-828,586	155,506		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	14,624,932		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	21,713,491		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	12,612,722		73.00
74.00	07400	RENAL DIALYSIS	-6,466	562,993		74.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	09000	CLINIC	-16,388	745,311		90.00
90.01	09001	HOMER GLEN LAB	0	0		90.01
90.02	09002	HOMER GLEN FEC	0	0		90.02
90.03	09003	WOMEN'S HEALTH	0	0		90.03
91.00	09100	EMERGENCY	-832,419	9,914,437		91.00
91.01	09101	OP MENTAL HEALTH	-17	481,463		91.01
91.02	09102	DIABETES CENTER	-744	225,508		91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
94.00	09400	HOME PROGRAM DIALYSIS	0	0		94.00
99.00	09900	CMHC	0	0		99.00
99.10	09910	CORF	0	0		99.10
101.00	10100	HOME HEALTH AGENCY	0	3,108,341		101.00
		SPECIAL PURPOSE COST CENTERS				
109.00	10900	PANCREAS ACQUISITION	0	0		109.00
110.00	11000	INTESTINAL ACQUISITION	0	0		110.00
111.00	11100	ISLET ACQUISITION	0	0		111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-36,770,516	333,672,190		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	14,968		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet A | Date/Time Prepared: 2/25/2019 3:00 pm

	Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
		6.00	7.00		
200.00	TOTAL (SUM OF LINES 118 through 199)	-36,770,516	333,687,158		200.00

RECLASSIFICATIONS | Provider CCN: 14-0213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet A-6 | Date/Time Prepared: 2/25/2019 3:00 pm

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
	A - STERILE PROCESSING				
1.00	ADULTS & PEDIATRICS	30.00	13,859	22,054	1.00
2.00	OPERATING ROOM	50.00	886,966	1,411,430	2.00
3.00	DELIVERY ROOM & LABOR ROOM	52.00	62,365	99,241	3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	6,929	11,027	4.00
5.00	CLINIC	90.00	3,960	6,301	5.00
6.00	EMERGENCY	91.00	15,839	25,204	6.00
	0		989,918	1,575,257	
	C - CAPITAL INSURANCE				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	217,423	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	230,370	2.00
	0		0	447,793	
	D - CHARGEABLE DRUGS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	12,612,722	1.00
	0		0	12,612,722	
	E - MALPRACTICE INSURANCE				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	5,926,398	1.00
	0		0	5,926,398	
	F - DEPRECIATION				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	16,838,774	1.00
	0		0	16,838,774	
	G - PHYSICIAN FEES				
1.00	ADULTS & PEDIATRICS	30.00	0	1,544,796	1.00
2.00	INTENSIVE CARE UNIT	31.00	0	709,215	2.00
3.00	SUBPROVIDER - IPF	40.00	0	378,942	3.00
4.00	SUBPROVIDER - IRF	41.00	0	108,790	4.00
5.00	OPERATING ROOM	50.00	0	36,693	5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	44,000	6.00
7.00	LABORATORY	60.00	0	54,167	7.00
8.00	RESPIRATORY THERAPY	65.00	0	88,332	8.00
9.00	SLEEP LAB	65.01	0	110,000	9.00
10.00	ELECTROCARDIOLOGY	69.00	0	144,999	10.00
11.00	ELECTROENCEPHALOGRAPHY	70.00	0	833,783	11.00
12.00	RENAL DIALYSIS	74.00	0	12,600	12.00
13.00	CLINIC	90.00	0	18,250	13.00
14.00	EMERGENCY	91.00	0	374,750	14.00
15.00	DIABETES CENTER	91.02	0	5,004	15.00
16.00	HOME HEALTH AGENCY	101.00	0	34,252	16.00
	0		0	4,498,573	
	H - LABOR AND DELIVERY				
1.00	ADULTS & PEDIATRICS	30.00	3,615,200	0	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	3,752,697	0	2.00
	0		7,367,897	0	
	I - SOCIAL SERVICES				
1.00	SOCIAL SERVICE	17.00	418,788	0	1.00
	0		418,788	0	
	K - CHARGEABLE SUPPLIES				
1.00	ADMINISTRATIVE & GENERAL	5.00	0	459,370	1.00
2.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	14,624,932	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	15,084,302	

RECLASSIFICATIONS | Provider CCN: 14-0213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet A-6 | Date/Time Prepared: 2/25/2019 3:00 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	L - DIABETES MANAGEMENT					
1.00	ADULTS & PEDIATRICS	30.00	80,664	883		1.00
	0		80,664	883		
	M - DIETARY RECLASS					
1.00	CAFETERIA	11.00	1,810,046	2,082,457		1.00
	0		1,810,046	2,082,457		
	N - IMPLANTABLE DEVICES					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	21,713,491		1.00
2.00		0.00	0	0		2.00
	0		0	21,713,491		
500.00	Grand Total: Increases		10,667,313	80,780,650		500.00

RECLASSIFICATIONS | Provider CCN: 14-0213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet A-6 | Date/Time Prepared: 2/25/2019 3:00 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - STERILE PROCESSING						
1.00	CENTRAL SERVICES & SUPPLY	14.00	989,918	1,575,257	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
	0		989,918	1,575,257			
	C - CAPITAL INSURANCE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	447,793	9		1.00
2.00		0.00	0	0	0		2.00
	0		0	447,793			
	D - CHARGEABLE DRUGS						
1.00	PHARMACY	15.00	0	12,612,722	0		1.00
	0		0	12,612,722			
	E - MALPRACTICE INSURANCE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	5,926,398	9		1.00
	0		0	5,926,398			
	F - DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	16,838,774	9		1.00
	0		0	16,838,774			
	G - PHYSICIAN FEES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	4,498,573	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
16.00		0.00	0	0	0		16.00
	0		0	4,498,573			
	H - LABOR AND DELIVERY						
1.00	NURSERY	43.00	7,367,897	0	0		1.00
2.00		0.00	0	0	0		2.00
	0		7,367,897	0			
	I - SOCIAL SERVICES						
1.00	ADMINISTRATIVE & GENERAL	5.00	418,788	0	0		1.00
	0		418,788	0			
	K - CHARGEABLE SUPPLIES						
1.00	NURSING ADMINISTRATION	13.00	0	22	0		1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	18,971	0		2.00
3.00	PHARMACY	15.00	0	48,106	0		3.00
4.00	PARAMED ED PRGM	23.00	0	1,393	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	393,412	0		5.00
6.00	INTENSIVE CARE UNIT	31.00	0	254,064	0		6.00
7.00	SUBPROVIDER - IPF	40.00	0	383	0		7.00
8.00	SUBPROVIDER - IRF	41.00	0	15,751	0		8.00
9.00	NURSERY	43.00	0	11,387	0		9.00
10.00	OPERATING ROOM	50.00	0	9,833,342	0		10.00
11.00	RECOVERY ROOM	51.00	0	736	0		11.00
12.00	DELIVERY ROOM & LABOR ROOM	52.00	0	357,960	0		12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	3,960,356	0		13.00
14.00	ULTRASOUND	54.01	0	7,418	0		14.00
15.00	CT SCAN	57.00	0	16,894	0		15.00
16.00	LABORATORY	60.00	0	2,293	0		16.00
17.00	RESPIRATORY THERAPY	65.00	0	4,962	0		17.00
18.00	PHYSICAL THERAPY	66.00	0	446	0		18.00
19.00	OCCUPATIONAL THERAPY	67.00	0	4,723	0		19.00
20.00	ELECTROCARDIOLOGY	69.00	0	274	0		20.00
21.00	ELECTROENCEPHALOGRAPHY	70.00	0	10,538	0		21.00
22.00	RENAL DIALYSIS	74.00	0	1,109	0		22.00
23.00	CLINIC	90.00	0	20,025	0		23.00
24.00	EMERGENCY	91.00	0	106,263	0		24.00
25.00	HOME HEALTH AGENCY	101.00	0	13,474	0		25.00
	0		0	15,084,302			

RECLASSIFICATIONS | Provider CCN: 14-0213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet A-6 | Date/Time Prepared: 2/25/2019 3:00 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	L - DIABETES MANAGEMENT						
1.00	DIABETES CENTER	91.02	80,664	883	0		1.00
	0		80,664	883			
	M - DIETARY RECLASS						
1.00	DIETARY	10.00	1,810,046	2,082,457	0		1.00
	0		1,810,046	2,082,457			
	N - IMPLANTABLE DEVICES						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	5,307,694	0		1.00
2.00	OPERATING ROOM	50.00	0	16,405,797	0		2.00
	0		0	21,713,491			
500.00	Grand Total: Decreases		10,667,313	80,780,650			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet A-7 Part I | Date/Time Prepared: 2/25/2019 3:00 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	19,840,244	0	0	0	0	1.00
2.00	Land Improvements	14,003,888	794,074	0	794,074	0	2.00
3.00	Buildings and Fixtures	333,260,750	0	0	0	0	3.00
4.00	Building Improvements	4,817,419	11,573,780	0	11,573,780	0	4.00
5.00	Fixed Equipment	18,574,585	166,298	0	166,298	0	5.00
6.00	Movable Equipment	234,684,501	0	0	0	1,535,572	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	625,181,387	12,534,152	0	12,534,152	1,535,572	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	625,181,387	12,534,152	0	12,534,152	1,535,572	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	19,840,244	0	1.00
2.00	Land Improvements	14,797,962	0	2.00
3.00	Buildings and Fixtures	333,260,750	0	3.00
4.00	Building Improvements	16,391,199	0	4.00
5.00	Fixed Equipment	18,740,883	0	5.00
6.00	Movable Equipment	233,148,929	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	636,179,967	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	636,179,967	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet A-7 Part II Date/Time Prepared: 2/25/2019 3:00 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	29,166,768	171,429	18,642,277	6,541,799	34,180	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	29,166,768	171,429	18,642,277	6,541,799	34,180	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	2,668,120	57,224,573	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	2.00
3.00	Total (sum of lines 1-2)	2,668,120	57,224,573	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet A-7 Part III Date/Time Prepared: 2/25/2019 3:00 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	403,031,037	0	403,031,037	0.633517	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	233,148,928	0	233,148,928	0.366483	0	2.00
3.00	Total (sum of lines 1-2)	636,179,965	0	636,179,965	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	4,348,025	171,429	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	17,056,197	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	21,404,222	171,429	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	8,651,748	6,541,799	34,180	2,668,120	22,415,301	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	17,056,197	2.00
3.00	Total (sum of lines 1-2)	8,651,748	6,541,799	34,180	2,668,120	39,471,498	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet A-8 | Date/Time Prepared: 2/25/2019 3:00 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)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-7,740,124			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	603,610			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	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	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet A-8 | Date/Time Prepared: 2/25/2019 3:00 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	
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
33.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.00
33.01	1996 DSR INTEXP	A	14,351	CAP REL COSTS-BLDG & FIXT	1.00	9	33.01
33.02	PROVIDER TAX ASSESSMENT IN A&G	B	-13,171,207	ADMINISTRATIVE & GENERAL	5.00	0	33.02
33.03	ADMINISTRATIVE MISC	B	-179,984	ADMINISTRATIVE & GENERAL	5.00	0	33.03
33.04	PHYSICIANS	A	-550,747	ADMINISTRATIVE & GENERAL	5.00	0	33.04
33.05	CONTRIBUTIONS EXPENSE	B	-166,442	ADMINISTRATIVE & GENERAL	5.00	0	33.05
33.06	BAD DEBTS	A	1,179,563	ADMINISTRATIVE & GENERAL	5.00	0	33.06
33.07	TELEPHONE BENEFITS	B	-16,835	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.07
33.08	TELEPHONE COSTS	A	-61,552	ADMINISTRATIVE & GENERAL	5.00	0	33.08
33.09	COMMUNITY RELATIONS	A	-1,218,141	ADMINISTRATIVE & GENERAL	5.00	0	33.09
33.10	OTHER REV - CAPITAL EXPENSE	B	-1,620,129	CAP REL COSTS-BLDG & FIXT	1.00	9	33.10
33.11	OTHER REV - EMPLOYEE BENEFIS	B	-52,950	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.11
33.12	OTHER REV A & G	B	-630,611	ADMINISTRATIVE & GENERAL	5.00	0	33.12
33.13	OTHER REV - OPERATION & PLANT	B	-3,315	OPERATION OF PLANT	7.00	0	33.13
33.14	OTHER REV - CAF'-EMP & GUESTS	B	-2,388,256	CAFETERIA	11.00	0	33.14
33.15	OTHER REV - VENDING MACHINES	B	-10,005	CAFETERIA	11.00	0	33.15
33.16	OTHER REVENUE-CENTRAL SUPPLY	B	-1,282	CENTRAL SERVICES & SUPPLY	14.00	0	33.16
33.17	OTHER REV - PHARMACY	B	-4,200	PHARMACY	15.00	0	33.17
33.18	OTHER REV - MED REC	B	-739	MEDICAL RECORDS & LIBRARY	16.00	0	33.18
33.19	OTHER REV - PARAMED ED PROGRAM	B	-157,022	PARAMED ED PRGM	23.00	0	33.19
33.20	OTHER REV - A & P	B	-71	ADULTS & PEDIATRICS	30.00	0	33.20
33.21	OTHER REV - ADULTS & PEDS	B	-43	INTENSIVE CARE UNIT	31.00	0	33.21
33.22	OTHER REV - REHAB	B	-2,000	SUBPROVIDER - IRF	41.00	0	33.22
33.23	OTHER REV - NURSERY	B	-4,835	NURSERY	43.00	0	33.23
33.24	OTHER REV - OPERATING ROOM	B	-69	OPERATING ROOM	50.00	0	33.24
33.25	OTHER REV - RADILOGY	B	-5,766	RADIOLOGY-DIAGNOSTIC	54.00	0	33.25
33.26	OTHER REV - LAB	B	-1,248	LABORATORY	60.00	0	33.26
33.27	OTHER REV - CARDIAC CATH	B	-39,480	ELECTROCARDIOLOGY	69.00	0	33.27
33.28	OTHER REV - CLINIC	B	-12	CLINIC	90.00	0	33.28
33.29	OTHER REV - ER	B	-503,673	EMERGENCY	91.00	0	33.29
33.30	OTHER REV - PSYCH	B	-17	OP MENTAL HEALTH	91.01	0	33.30
33.31	INVESTMENT INCOME	B	-9,990,529	CAP REL COSTS-BLDG & FIXT	1.00	11	33.31
33.32	AHA & IHA DUES-POLITICAL LOBBY	B	-46,756	ADMINISTRATIVE & GENERAL	5.00	0	33.32
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-36,770,516				50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 14-0213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet A-8-1 | Date/Time Prepared: 2/25/2019 3:00 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	5.00	ADMINISTRATIVE & GENERAL	MANAGEMENT FEE	6,730,259	8,104,813	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	JV OPERATING EXP	1,978,164	0	2.00
3.00	0.00			0	0	3.00
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			8,708,423	8,104,813	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	G	SILVER CROSS HO	100.00	SILVER CROSS HO	100.00	6.00
7.00	C	UCMS/SCH ONC JV	60.00	UCMS/SCH ONC JV	60.00	7.00
8.00			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: 14-0213	Period: From 10/01/2017 To 09/30/2018	Worksheet A-8-1 Date/Time Prepared: 2/25/2019 3:00 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	-1,374,554	0		1.00
2.00	1,978,164	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
5.00	603,610			5.00

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

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

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

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

6.00	HOME OFFICE		6.00
7.00	RADIOLOGY ONCOL		7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 14-0213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet A-8-2 | Date/Time Prepared: 2/25/2019 3:00 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	3,583,826	3,583,826	0	211,500	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	1,544,796	1,410,946	133,850	177,200	858	2.00
3.00	31.00	INTENSIVE CARE UNIT	709,215	630,889	78,326	154,100	470	3.00
4.00	40.00	SUBPROVIDER - IPF	378,942	361,542	17,400	154,100	74	4.00
5.00	41.00	SUBPROVIDER - IRF	108,790	108,790	0	208,000	0	5.00
6.00	50.00	OPERATING ROOM	36,693	0	36,693	177,200	544	6.00
7.00	54.00	RADIOLOGY-DIAGNOSTIC	44,000	0	44,000	177,200	203	7.00
8.00	60.00	LABORATORY	54,167	0	54,167	177,200	947	8.00
9.00	65.00	RESPIRATORY THERAPY	88,332	88,332	0	177,200	0	9.00
10.00	65.01	SLEEP LAB	110,000	110,000	0	215,700	0	10.00
11.00	69.00	ELECTROCARDIOLOGY	144,999	104,999	40,000	177,200	270	11.00
12.00	70.00	ELECTROENCEPHALOGRAPHY	833,783	807,700	26,083	177,200	61	12.00
13.00	74.00	RENAL DIALYSIS	12,600	0	12,600	177,200	72	13.00
14.00	90.00	CLINIC	18,250	15,000	3,250	177,200	22	14.00
15.00	91.00	EMERGENCY	374,750	309,750	65,000	177,200	540	15.00
16.00	91.02	DIABETES CENTER	5,004	0	5,004	177,200	50	16.00
200.00			8,048,147	7,531,774	516,373		4,111	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	73,095	3,655	0	0	0	2.00
3.00	31.00	INTENSIVE CARE UNIT	34,821	1,741	0	0	0	3.00
4.00	40.00	SUBPROVIDER - IPF	5,482	274	0	0	0	4.00
5.00	41.00	SUBPROVIDER - IRF	0	0	0	0	0	5.00
6.00	50.00	OPERATING ROOM	46,345	2,317	0	0	0	6.00
7.00	54.00	RADIOLOGY-DIAGNOSTIC	17,294	865	0	0	0	7.00
8.00	60.00	LABORATORY	80,677	4,034	0	0	0	8.00
9.00	65.00	RESPIRATORY THERAPY	0	0	0	0	0	9.00
10.00	65.01	SLEEP LAB	0	0	0	0	0	10.00
11.00	69.00	ELECTROCARDIOLOGY	23,002	1,150	0	0	0	11.00
12.00	70.00	ELECTROENCEPHALOGRAPHY	5,197	260	0	0	0	12.00
13.00	74.00	RENAL DIALYSIS	6,134	307	0	0	0	13.00
14.00	90.00	CLINIC	1,874	94	0	0	0	14.00
15.00	91.00	EMERGENCY	46,004	2,300	0	0	0	15.00
16.00	91.02	DIABETES CENTER	4,260	213	0	0	0	16.00
200.00			344,185	17,210	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	3,583,826		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	73,095	60,755	1,471,701		2.00
3.00	31.00	INTENSIVE CARE UNIT	0	34,821	43,505	674,394		3.00
4.00	40.00	SUBPROVIDER - IPF	0	5,482	11,918	373,460		4.00
5.00	41.00	SUBPROVIDER - IRF	0	0	0	108,790		5.00
6.00	50.00	OPERATING ROOM	0	46,345	0	0		6.00
7.00	54.00	RADIOLOGY-DIAGNOSTIC	0	17,294	26,706	26,706		7.00
8.00	60.00	LABORATORY	0	80,677	0	0		8.00
9.00	65.00	RESPIRATORY THERAPY	0	0	0	88,332		9.00
10.00	65.01	SLEEP LAB	0	0	0	110,000		10.00
11.00	69.00	ELECTROCARDIOLOGY	0	23,002	16,998	121,997		11.00
12.00	70.00	ELECTROENCEPHALOGRAPHY	0	5,197	20,886	828,586		12.00
13.00	74.00	RENAL DIALYSIS	0	6,134	6,466	6,466		13.00
14.00	90.00	CLINIC	0	1,874	1,376	16,376		14.00
15.00	91.00	EMERGENCY	0	46,004	18,996	328,746		15.00
16.00	91.02	DIABETES CENTER	0	4,260	744	744		16.00
200.00			0	344,185	208,350	7,740,124		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B Part I | Date/Time Prepared: 2/25/2019 3:00 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	22,415,301	22,415,301				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	17,056,197		17,056,197			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	34,450,572	83,059	5,332	34,538,963		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	49,006,836	5,152,099	8,305,085	4,914,348	67,378,368	5.00
7.00	00700	OPERATION OF PLANT	9,747,486	275,795	65,850	850,057	10,939,188	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	92,985	94,866	0	18,354	206,205	8.00
9.00	00900	HOUSEKEEPING	3,946,014	235,191	54,289	671,020	4,906,514	9.00
10.00	01000	DIETARY	1,236,466	934,715	13,787	156,987	2,341,955	10.00
11.00	01100	CAFETERIA	1,494,242	0	46,639	494,210	2,035,091	11.00
13.00	01300	NURSING ADMINISTRATION	2,807,404	118,315	64,220	753,488	3,743,427	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,181,883	754,239	256,072	180,992	2,373,186	14.00
15.00	01500	PHARMACY	5,617,099	311,338	0	969,699	6,898,136	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,892,732	44,060	9,416	769,580	4,715,788	16.00
17.00	01700	SOCIAL SERVICE	418,788	0	0	114,345	533,133	17.00
23.00	02300	PARAMED ED PRGM	621,827	34,474	52,494	107,117	815,912	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	29,970,018	4,847,756	462,631	7,312,338	42,592,743	30.00
31.00	03100	INTENSIVE CARE UNIT	6,997,607	698,455	270,605	1,641,594	9,608,261	31.00
40.00	04000	SUBPROVIDER - IPF	2,321,126	455,777	24,775	518,777	3,320,455	40.00
41.00	04100	SUBPROVIDER - IRF	4,400,622	829,687	28,313	1,040,321	6,298,943	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	2,181,677	1,872,844	190,493	436,902	4,681,916	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	21,743,681	2,258,520	2,332,988	2,936,203	29,271,392	50.00
51.00	05100	RECOVERY ROOM	1,468,351	178,419	40,363	376,468	2,063,601	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,380,750	0	348,194	1,041,653	5,770,597	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,741,090	1,008,477	2,593,284	2,335,999	21,678,850	54.00
54.01	05401	ULTRASOUND	1,559,147	123,499	213,476	328,528	2,224,650	54.01
57.00	05700	CT SCAN	2,303,552	110,787	503,294	338,684	3,256,317	57.00
58.00	05800	MRI	1,261,246	142,834	328,959	187,547	1,920,586	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	11,092,305	24,642	57,042	1,094,281	12,268,270	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,014,429	0	6,522	72,826	2,093,777	63.00
65.00	06500	RESPIRATORY THERAPY	2,157,901	80,838	64,533	497,405	2,800,677	65.00
65.01	06501	SLEEP LAB	423,194	0	33,822	68,072	525,088	65.01
66.00	06600	PHYSICAL THERAPY	1,777,976	10,244	19,632	382,686	2,190,538	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,196,276	0	14,353	490,361	2,700,990	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,550,706	59,898	93,653	374,634	2,078,891	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	155,506	42,784	10,606	36,632	245,528	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	14,624,932	0	0	0	14,624,932	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	21,713,491	0	0	0	21,713,491	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	12,612,722	0	0	0	12,612,722	73.00
74.00	07400	RENAL DIALYSIS	562,993	119,138	38,760	112,154	833,045	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	745,311	0	3,270	150,125	898,706	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	9,914,437	1,311,958	499,201	2,052,355	13,777,951	91.00
91.01	09101	OP MENTAL HEALTH	481,463	126,173	2,130	128,544	738,310	91.01
91.02	09102	DIABETES CENTER	225,508	0	554	59,755	285,817	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	3,108,341	0	1,560	519,835	3,629,736	101.00
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B Part I Date/Time Prepared: 2/25/2019 3:00 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
				BLDG & FIXT	MVBLE EQUIP			
			0	1.00	2.00	4.00	4A	
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	333,672,190	22,340,881	17,056,197	34,534,876	333,593,683	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	14,968	74,420	0	4,087	93,475	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	333,687,158	22,415,301	17,056,197	34,538,963	333,687,158	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B Part I | Date/Time Prepared: 2/25/2019 3:00 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	67,378,368					5.00
7.00	00700	OPERATION OF PLANT	2,767,702	13,706,890				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	52,172	76,922	335,299			8.00
9.00	00900	HOUSEKEEPING	1,241,387	190,704	0	6,338,605		9.00
10.00	01000	DIETARY	592,533	757,914	0	357,469	4,049,871	10.00
11.00	01100	CAFETERIA	514,894	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	947,117	95,936	0	45,248	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	600,435	611,575	321	288,448	0	14.00
15.00	01500	PHARMACY	1,745,284	252,449	0	119,067	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,193,132	35,726	0	16,850	0	16.00
17.00	01700	SOCIAL SERVICE	134,887	0	0	0	0	17.00
23.00	02300	PARAMED ED PRGM	206,432	27,954	10,917	13,184	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	10,776,419	3,930,802	140,364	1,853,956	2,403,733	30.00
31.00	03100	INTENSIVE CARE UNIT	2,430,967	566,342	25,263	267,114	756,721	31.00
40.00	04000	SUBPROVIDER - IPF	840,102	369,567	954	174,305	247,068	40.00
41.00	04100	SUBPROVIDER - IRF	1,593,683	672,752	4,798	317,302	642,349	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	1,184,562	1,518,596	0	716,243	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	7,405,896	1,831,321	46,473	863,740	0	50.00
51.00	05100	RECOVERY ROOM	522,108	144,671	9,562	68,234	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,460,007	0	17,812	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,484,922	817,723	19,925	385,678	0	54.00
54.01	05401	ULTRASOUND	562,854	100,139	2,222	47,230	0	54.01
57.00	05700	CT SCAN	823,874	89,831	2,222	42,369	0	57.00
58.00	05800	MRI	485,924	115,817	3,490	54,625	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	3,103,970	19,981	0	9,424	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	529,742	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	708,594	65,547	0	30,915	0	65.00
65.01	06501	SLEEP LAB	132,851	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	554,224	8,306	0	3,918	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	683,372	0	6,468	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	525,976	48,568	1,150	22,907	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	62,121	34,692	0	16,362	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,700,225	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,493,687	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,191,120	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	210,767	96,603	0	45,563	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	227,380	0	121	0	0	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	3,485,932	1,063,801	43,237	501,740	0	91.00
91.01	09101	OP MENTAL HEALTH	186,798	102,307	0	48,253	0	91.01
91.02	09102	DIABETES CENTER	72,314	0	0	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	918,352	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	67,354,718	13,646,546	335,299	6,310,144	4,049,871	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	23,650	60,344	0	28,461	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B Part I Date/Time Prepared: 2/25/2019 3:00 pm

	Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	67,378,368	13,706,890	335,299	6,338,605	4,049,871	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B Part I | Date/Time Prepared: 2/25/2019 3:00 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	2,549,985					11.00
13.00	01300	NURSING ADMINISTRATION	58,469	4,890,197				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	75,443	0	3,949,408			14.00
15.00	01500	PHARMACY	66,013	0	21,857	9,102,806		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	88,646	0	1,431	0	6,051,573	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
23.00	02300	PARAMED ED PRGM	9,430	0	20,219	40,814	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	637,498	2,721,315	290,678	3,949	2,394,905	30.00
31.00	03100	INTENSIVE CARE UNIT	139,570	592,722	92,425	15,635	737,181	31.00
40.00	04000	SUBPROVIDER - IPF	54,696	0	4,456	0	192,383	40.00
41.00	04100	SUBPROVIDER - IRF	98,076	422,066	18,745	0	187,095	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	211,241	903,490	26,974	0	258,635	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	247,077	0	463,379	823	0	50.00
51.00	05100	RECOVERY ROOM	26,405	0	6,058	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	45,295	3,018	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	222,558	0	150,451	23,502	0	54.00
54.01	05401	ULTRASOUND	28,291	0	16,079	0	0	54.01
57.00	05700	CT SCAN	30,177	0	40,586	0	0	57.00
58.00	05800	MRI	13,203	0	6,015	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	124,482	0	607,406	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	7,544	0	25,825	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	52,810	0	28,316	0	0	65.00
65.01	06501	SLEEP LAB	9,430	0	3,897	0	0	65.01
66.00	06600	PHYSICAL THERAPY	30,177	0	1,358	0	557,085	66.00
67.00	06700	OCCUPATIONAL THERAPY	43,380	0	5,447	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	35,836	0	5,528	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	5,658	0	805	0	129,396	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	1,886,091	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	9,001,741	0	73.00
74.00	07400	RENAL DIALYSIS	7,544	31,404	12,230	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	11,317	0	9,552	0	24,417	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	194,267	0	146,459	13,324	1,570,476	91.00
91.01	09101	OP MENTAL HEALTH	13,203	0	1,147	0	0	91.01
91.02	09102	DIABETES CENTER	7,544	34,069	390	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	185,131	10,309	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,549,985	4,890,197	3,949,408	9,102,806	6,051,573	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

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B Part I Date/Time Prepared: 2/25/2019 3:00 pm

	Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	2,549,985	4,890,197	3,949,408	9,102,806	6,051,573	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B Part I | Date/Time Prepared: 2/25/2019 3:00 pm

		Cost Center Description	SOCIAL SERVICE	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	23.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	668,020					17.00
23.00	02300	PARAMED ED PRGM	0	1,144,862				23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	580,248	0	68,326,610	0	68,326,610	30.00
31.00	03100	INTENSIVE CARE UNIT	35,583	40,124	15,307,908	0	15,307,908	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	5,203,986	0	5,203,986	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	10,255,809	0	10,255,809	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	9,501,657	0	9,501,657	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	40,130,101	0	40,130,101	50.00
51.00	05100	RECOVERY ROOM	0	0	2,840,639	0	2,840,639	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	41,888	7,338,617	0	7,338,617	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	28,783,609	0	28,783,609	54.00
54.01	05401	ULTRASOUND	0	0	2,981,465	0	2,981,465	54.01
57.00	05700	CT SCAN	0	0	4,285,376	0	4,285,376	57.00
58.00	05800	MRI	0	0	2,599,660	0	2,599,660	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	16,133,533	0	16,133,533	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	2,656,888	0	2,656,888	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	3,686,859	0	3,686,859	65.00
65.01	06501	SLEEP LAB	0	0	671,266	0	671,266	65.01
66.00	06600	PHYSICAL THERAPY	0	0	3,345,606	0	3,345,606	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	3,439,657	0	3,439,657	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	42,770	2,761,626	0	2,761,626	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	494,562	0	494,562	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	20,211,248	0	20,211,248	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	27,207,178	0	27,207,178	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	24,805,583	0	24,805,583	73.00
74.00	07400	RENAL DIALYSIS	0	0	1,237,156	0	1,237,156	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	8,303	0	1,179,796	0	1,179,796	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	43,886	1,020,080	21,861,153	0	21,861,153	91.00
91.01	09101	OP MENTAL HEALTH	0	0	1,090,018	0	1,090,018	91.01
91.02	09102	DIABETES CENTER	0	0	400,134	0	400,134	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	4,743,528	0	4,743,528	101.00
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	668,020	1,144,862	333,481,228	0	333,481,228	118.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B Part I Date/Time Prepared: 2/25/2019 3:00 pm

		Cost Center Description	SOCIAL SERVICE	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	23.00	24.00	25.00	26.00	
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	205,930	0	205,930	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments		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)	668,020	1,144,862	333,687,158	0	333,687,158	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B Part II Date/Time Prepared: 2/25/2019 3:00 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	83,059	5,332	88,391	88,391	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	5,152,099	8,305,085	13,457,184	12,581	5.00
7.00	00700	OPERATION OF PLANT	0	275,795	65,850	341,645	2,176	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	94,866	0	94,866	47	8.00
9.00	00900	HOUSEKEEPING	0	235,191	54,289	289,480	1,718	9.00
10.00	01000	DIETARY	0	934,715	13,787	948,502	402	10.00
11.00	01100	CAFETERIA	0	0	46,639	46,639	1,265	11.00
13.00	01300	NURSING ADMINISTRATION	0	118,315	64,220	182,535	1,929	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	754,239	256,072	1,010,311	463	14.00
15.00	01500	PHARMACY	0	311,338	0	311,338	2,483	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	44,060	9,416	53,476	1,970	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	293	17.00
23.00	02300	PARAMED ED PRGM	0	34,474	52,494	86,968	274	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	4,847,756	462,631	5,310,387	18,691	30.00
31.00	03100	INTENSIVE CARE UNIT	0	698,455	270,605	969,060	4,203	31.00
40.00	04000	SUBPROVIDER - IPF	0	455,777	24,775	480,552	1,328	40.00
41.00	04100	SUBPROVIDER - IRF	0	829,687	28,313	858,000	2,663	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	1,872,844	190,493	2,063,337	1,119	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	2,258,520	2,332,988	4,591,508	7,517	50.00
51.00	05100	RECOVERY ROOM	0	178,419	40,363	218,782	964	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	348,194	348,194	2,667	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,008,477	2,593,284	3,601,761	5,980	54.00
54.01	05401	ULTRASOUND	0	123,499	213,476	336,975	841	54.01
57.00	05700	CT SCAN	0	110,787	503,294	614,081	867	57.00
58.00	05800	MRI	0	142,834	328,959	471,793	480	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	24,642	57,042	81,684	2,801	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	6,522	6,522	186	63.00
65.00	06500	RESPIRATORY THERAPY	0	80,838	64,533	145,371	1,273	65.00
65.01	06501	SLEEP LAB	0	0	33,822	33,822	174	65.01
66.00	06600	PHYSICAL THERAPY	0	10,244	19,632	29,876	980	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	14,353	14,353	1,255	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	59,898	93,653	153,551	959	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	42,784	10,606	53,390	94	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	119,138	38,760	157,898	287	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	3,270	3,270	384	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	1,311,958	499,201	1,811,159	5,254	91.00
91.01	09101	OP MENTAL HEALTH	0	126,173	2,130	128,303	329	91.01
91.02	09102	DIABETES CENTER	0	0	554	554	153	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	1,560	1,560	1,331	101.00
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	22,340,881	17,056,197	39,397,078	88,381	118.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B Part II Date/Time Prepared: 2/25/2019 3:00 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	
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	74,420	0	74,420	10	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	22,415,301	17,056,197	39,471,498	88,391	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B Part II | Date/Time Prepared: 2/25/2019 3:00 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	13,469,765					5.00
7.00	00700	OPERATION OF PLANT	553,293	897,114				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	10,430	5,035	110,378			8.00
9.00	00900	HOUSEKEEPING	248,167	12,482	0	551,847		9.00
10.00	01000	DIETARY	118,454	49,605	0	31,122	1,148,085	10.00
11.00	01100	CAFETERIA	102,933	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	189,339	6,279	0	3,939	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	120,033	40,027	106	25,113	0	14.00
15.00	01500	PHARMACY	348,901	16,523	0	10,366	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	238,520	2,338	0	1,467	0	16.00
17.00	01700	SOCIAL SERVICE	26,965	0	0	0	0	17.00
23.00	02300	PARAMED ED PRGM	41,268	1,830	3,594	1,148	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,154,431	257,268	46,207	161,406	681,427	30.00
31.00	03100	INTENSIVE CARE UNIT	485,976	37,067	8,317	23,255	214,520	31.00
40.00	04000	SUBPROVIDER - IPF	167,945	24,188	314	15,175	70,041	40.00
41.00	04100	SUBPROVIDER - IRF	318,594	44,032	1,579	27,625	182,097	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	236,807	99,392	0	62,357	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,480,518	119,860	15,299	75,198	0	50.00
51.00	05100	RECOVERY ROOM	104,375	9,469	3,148	5,941	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	291,871	0	5,864	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,096,495	53,520	6,559	33,578	0	54.00
54.01	05401	ULTRASOUND	112,521	6,554	731	4,112	0	54.01
57.00	05700	CT SCAN	164,701	5,879	731	3,689	0	57.00
58.00	05800	MRI	97,141	7,580	1,149	4,756	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	620,517	1,308	0	820	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	105,901	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	141,655	4,290	0	2,692	0	65.00
65.01	06501	SLEEP LAB	26,558	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	110,795	544	0	341	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	136,613	0	2,129	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	105,148	3,179	378	1,994	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	12,419	2,271	0	1,425	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	739,714	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,098,247	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	637,939	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	42,135	6,323	0	3,967	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	45,456	0	40	0	0	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	696,875	69,626	14,233	43,682	0	91.00
91.01	09101	OP MENTAL HEALTH	37,343	6,696	0	4,201	0	91.01
91.02	09102	DIABETES CENTER	14,456	0	0	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	183,588	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	13,465,037	893,165	110,378	549,369	1,148,085	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,728	3,949	0	2,478	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B Part II Date/Time Prepared: 2/25/2019 3:00 pm

	Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	13,469,765	897,114	110,378	551,847	1,148,085	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B Part II | Date/Time Prepared: 2/25/2019 3:00 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	150,837					11.00
13.00	01300	NURSING ADMINISTRATION	3,459	387,480				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	4,463	0	1,200,516			14.00
15.00	01500	PHARMACY	3,905	0	6,644	700,160		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,244	0	435	0	303,450	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
23.00	02300	PARAMED ED PRGM	558	0	6,146	3,139	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	37,710	215,627	88,359	304	120,091	30.00
31.00	03100	INTENSIVE CARE UNIT	8,256	46,965	28,095	1,203	36,965	31.00
40.00	04000	SUBPROVIDER - IPF	3,235	0	1,355	0	9,647	40.00
41.00	04100	SUBPROVIDER - IRF	5,801	33,443	5,698	0	9,382	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	12,495	71,589	8,199	0	12,969	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	14,615	0	140,856	63	0	50.00
51.00	05100	RECOVERY ROOM	1,562	0	1,842	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	13,769	232	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,165	0	45,734	1,808	0	54.00
54.01	05401	ULTRASOUND	1,673	0	4,888	0	0	54.01
57.00	05700	CT SCAN	1,785	0	12,337	0	0	57.00
58.00	05800	MRI	781	0	1,829	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	7,363	0	184,637	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	446	0	7,850	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	3,124	0	8,608	0	0	65.00
65.01	06501	SLEEP LAB	558	0	1,184	0	0	65.01
66.00	06600	PHYSICAL THERAPY	1,785	0	413	0	27,934	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,566	0	1,656	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,120	0	1,680	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	335	0	245	0	6,488	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	573,314	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	692,386	0	73.00
74.00	07400	RENAL DIALYSIS	446	2,488	3,718	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	669	0	2,903	0	1,224	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	11,491	0	44,520	1,025	78,750	91.00
91.01	09101	OP MENTAL HEALTH	781	0	349	0	0	91.01
91.02	09102	DIABETES CENTER	446	2,699	119	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	14,669	3,134	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	150,837	387,480	1,200,516	700,160	303,450	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

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B Part II Date/Time Prepared: 2/25/2019 3:00 pm

	Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	150,837	387,480	1,200,516	700,160	303,450	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B Part II | Date/Time Prepared: 2/25/2019 3:00 pm

		Cost Center Description	SOCIAL SERVICE	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	23.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	27,258					17.00
23.00	02300	PARAMED ED PRGM	0	144,925				23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	23,676		9,115,584	0	9,115,584	30.00
31.00	03100	INTENSIVE CARE UNIT	1,452		1,865,334	0	1,865,334	31.00
40.00	04000	SUBPROVIDER - IPF	0		773,780	0	773,780	40.00
41.00	04100	SUBPROVIDER - IRF	0		1,488,914	0	1,488,914	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	42.00
43.00	04300	NURSERY	0		2,568,264	0	2,568,264	43.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
45.00	04500	NURSING FACILITY	0		0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0		6,445,434	0	6,445,434	50.00
51.00	05100	RECOVERY ROOM	0		346,083	0	346,083	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		662,597	0	662,597	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		4,858,600	0	4,858,600	54.00
54.01	05401	ULTRASOUND	0		468,295	0	468,295	54.01
57.00	05700	CT SCAN	0		804,070	0	804,070	57.00
58.00	05800	MRI	0		585,509	0	585,509	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	0		899,130	0	899,130	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0		120,905	0	120,905	63.00
65.00	06500	RESPIRATORY THERAPY	0		307,013	0	307,013	65.00
65.01	06501	SLEEP LAB	0		62,296	0	62,296	65.01
66.00	06600	PHYSICAL THERAPY	0		172,668	0	172,668	66.00
67.00	06700	OCCUPATIONAL THERAPY	0		158,572	0	158,572	67.00
68.00	06800	SPEECH PATHOLOGY	0		0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0		269,009	0	269,009	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		76,667	0	76,667	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		1,313,028	0	1,313,028	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		1,098,247	0	1,098,247	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		1,330,325	0	1,330,325	73.00
74.00	07400	RENAL DIALYSIS	0		217,262	0	217,262	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000	CLINIC	339		54,285	0	54,285	90.00
90.01	09001	HOMER GLEN LAB	0		0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0		0	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0		0	0	0	90.03
91.00	09100	EMERGENCY	1,791		2,778,406	0	2,778,406	91.00
91.01	09101	OP MENTAL HEALTH	0		178,002	0	178,002	91.01
91.02	09102	DIABETES CENTER	0		18,427	0	18,427	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0		0	0	0	94.00
99.00	09900	CMHC	0		0	0	0	99.00
99.10	09910	CORF	0		0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0		204,282	0	204,282	101.00
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0		0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0		0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0		0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	27,258	0	39,240,988	0	39,240,988	118.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B Part II Date/Time Prepared: 2/25/2019 3:00 pm

		Cost Center Description	SOCIAL SERVICE	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	23.00	24.00	25.00	26.00	
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		85,585	0	85,585	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		0	0	0	192.00
200.00		Cross Foot Adjustments		144,925	144,925	0	144,925	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	27,258	144,925	39,471,498	0	39,471,498	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B-1 | Date/Time Prepared: 2/25/2019 3:00 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	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	544,870					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		13,045,171				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,019	4,078	126,499,224			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	125,237	6,352,016	17,998,835	-67,378,368	266,308,790	5.00
7.00	00700	OPERATION OF PLANT	6,704	50,364	3,113,341	0	10,939,188	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,306	0	67,221	0	206,205	8.00
9.00	00900	HOUSEKEEPING	5,717	41,522	2,457,617	0	4,906,514	9.00
10.00	01000	DIETARY	22,721	10,545	574,967	0	2,341,955	10.00
11.00	01100	CAFETERIA	0	35,671	1,810,046	0	2,035,091	11.00
13.00	01300	NURSING ADMINISTRATION	2,876	49,118	2,759,657	0	3,743,427	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	18,334	195,853	662,883	0	2,373,186	14.00
15.00	01500	PHARMACY	7,568	0	3,551,528	0	6,898,136	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,071	7,202	2,818,593	0	4,715,788	16.00
17.00	01700	SOCIAL SERVICE	0	0	418,788	0	533,133	17.00
23.00	02300	PARAMED ED PRGM	838	40,149	392,318	0	815,912	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	117,839	353,836	26,781,524	0	42,592,743	30.00
31.00	03100	INTENSIVE CARE UNIT	16,978	206,968	6,012,351	0	9,608,261	31.00
40.00	04000	SUBPROVIDER - IPF	11,079	18,949	1,900,025	0	3,320,455	40.00
41.00	04100	SUBPROVIDER - IRF	20,168	21,655	3,810,184	0	6,298,943	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	45,525	145,696	1,600,155	0	4,681,916	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	54,900	1,784,350	10,753,865	0	29,271,392	50.00
51.00	05100	RECOVERY ROOM	4,337	30,871	1,378,815	0	2,063,601	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	266,311	3,815,062	0	5,770,597	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	24,514	1,983,434	8,555,614	0	21,678,850	54.00
54.01	05401	ULTRASOUND	3,002	163,274	1,203,237	0	2,224,650	54.01
57.00	05700	CT SCAN	2,693	384,937	1,240,431	0	3,256,317	57.00
58.00	05800	MRI	3,472	251,599	686,892	0	1,920,586	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	599	43,628	4,007,811	0	12,268,270	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	4,988	266,725	0	2,093,777	63.00
65.00	06500	RESPIRATORY THERAPY	1,965	49,357	1,821,748	0	2,800,677	65.00
65.01	06501	SLEEP LAB	0	25,868	249,313	0	525,088	65.01
66.00	06600	PHYSICAL THERAPY	249	15,015	1,401,590	0	2,190,538	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	10,978	1,795,950	0	2,700,990	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,456	71,629	1,372,100	0	2,078,891	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,040	8,112	134,165	0	245,528	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	14,624,932	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	21,713,491	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	12,612,722	73.00
74.00	07400	RENAL DIALYSIS	2,896	29,645	410,764	0	833,045	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	2,501	549,834	0	898,706	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	31,891	381,806	7,516,764	0	13,777,951	91.00
91.01	09101	OP MENTAL HEALTH	3,067	1,629	470,792	0	738,310	91.01
91.02	09102	DIABETES CENTER	0	424	218,853	0	285,817	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	1,193	1,903,898	0	3,629,736	101.00
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B-1 | Date/Time Prepared: 2/25/2019 3:00 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	543,061	13,045,171	126,484,256	-67,378,368	266,215,315	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,809	0	14,968	0	93,475	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	22,415,301	17,056,197	34,538,963		67,378,368	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	41.138806	1.307472	0.273037		0.253008	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			88,391		13,469,765	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000699		0.050579	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B-1 | Date/Time Prepared: 2/25/2019 3:00 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (NUMBER HOUSED)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	410,910					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,306	2,474,946				8.00
9.00	00900	HOUSEKEEPING	5,717	0	402,887			9.00
10.00	01000	DIETARY	22,721	0	22,721	278,249		10.00
11.00	01100	CAFETERIA	0	0	0	0	1,352	11.00
13.00	01300	NURSING ADMINISTRATION	2,876	0	2,876	0	31	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	18,334	2,367	18,334	0	40	14.00
15.00	01500	PHARMACY	7,568	0	7,568	0	35	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,071	0	1,071	0	47	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
23.00	02300	PARAMED ED PRGM	838	80,579	838	0	5	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	117,839	1,036,071	117,839	165,150	338	30.00
31.00	03100	INTENSIVE CARE UNIT	16,978	186,478	16,978	51,991	74	31.00
40.00	04000	SUBPROVIDER - IPF	11,079	7,042	11,079	16,975	29	40.00
41.00	04100	SUBPROVIDER - IRF	20,168	35,415	20,168	44,133	52	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	45,525	0	45,525	0	112	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	54,900	343,036	54,900	0	131	50.00
51.00	05100	RECOVERY ROOM	4,337	70,579	4,337	0	14	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	131,478	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	24,514	147,076	24,514	0	118	54.00
54.01	05401	ULTRASOUND	3,002	16,398	3,002	0	15	54.01
57.00	05700	CT SCAN	2,693	16,398	2,693	0	16	57.00
58.00	05800	MRI	3,472	25,762	3,472	0	7	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	599	0	599	0	66	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	4	63.00
65.00	06500	RESPIRATORY THERAPY	1,965	0	1,965	0	28	65.00
65.01	06501	SLEEP LAB	0	0	0	0	5	65.01
66.00	06600	PHYSICAL THERAPY	249	0	249	0	16	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	47,741	0	0	23	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,456	8,486	1,456	0	19	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,040	0	1,040	0	3	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	2,896	0	2,896	0	4	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	893	0	0	6	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	31,891	319,147	31,891	0	103	91.00
91.01	09101	OP MENTAL HEALTH	3,067	0	3,067	0	7	91.01
91.02	09102	DIABETES CENTER	0	0	0	0	4	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	409,101	2,474,946	401,078	278,249	1,352	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,809	0	1,809	0	0	190.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B-1 | Date/Time Prepared: 2/25/2019 3:00 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (NUMBER HOUSED)	
			7.00	8.00	9.00	10.00	11.00	
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	13,706,890	335,299	6,338,605	4,049,871	2,549,985	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	33.357402	0.135477	15.732960	14.554845	1,886.083580	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	897,114	110,378	551,847	1,148,085	150,837	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	2.183237	0.044598	1.369731	4.126106	111.565828	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B-1 | Date/Time Prepared: 2/25/2019 3:00 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	
			13.00	14.00	15.00	16.00	17.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	1,262,865					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	30,624,118				14.00
15.00	01500	PHARMACY	0	169,481	12,754,328			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	11,099	0	38,911		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	2,816	17.00
23.00	02300	PARAMED ED PRGM	0	156,778	57,186	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	702,764	2,253,947	5,533	15,399	2,446	30.00
31.00	03100	INTENSIVE CARE UNIT	153,067	716,675	21,907	4,740	150	31.00
40.00	04000	SUBPROVIDER - IPF	0	34,556	0	1,237	0	40.00
41.00	04100	SUBPROVIDER - IRF	108,996	145,347	0	1,203	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	233,321	209,157	0	1,663	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	3,593,089	1,153	0	0	50.00
51.00	05100	RECOVERY ROOM	0	46,978	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	351,225	4,228	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,166,616	32,930	0	0	54.00
54.01	05401	ULTRASOUND	0	124,679	0	0	0	54.01
57.00	05700	CT SCAN	0	314,709	0	0	0	57.00
58.00	05800	MRI	0	46,644	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	4,709,886	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	200,246	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	219,569	0	0	0	65.00
65.01	06501	SLEEP LAB	0	30,215	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	10,531	0	3,582	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	42,239	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	42,866	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	6,245	0	832	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	14,624,933	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	12,612,722	0	0	73.00
74.00	07400	RENAL DIALYSIS	8,110	94,830	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	74,064	0	157	35	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	1,135,659	18,669	10,098	185	91.00
91.01	09101	OP MENTAL HEALTH	0	8,893	0	0	0	91.01
91.02	09102	DIABETES CENTER	8,798	3,027	0	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	47,809	79,935	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,262,865	30,624,118	12,754,328	38,911	2,816	118.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B-1 | Date/Time Prepared: 2/25/2019 3:00 pm

		Cost Center Description	NURSING ADMINISTRATION (DIRECT NRSING)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	
			13.00	14.00	15.00	16.00	17.00	
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	4,890,197	3,949,408	9,102,806	6,051,573	668,020	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	3.872304	0.128964	0.713703	155.523451	237.223011	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	387,480	1,200,516	700,160	303,450	27,258	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.306826	0.039202	0.054896	7.798566	9.679688	205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)						206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B-1 | Date/Time Prepared: 2/25/2019 3:00 pm

		Cost Center Description	PARAMED ED PRGM (ASSIGNED TIME)	
			23.00	
		GENERAL SERVICE COST CENTERS		
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE		17.00
23.00	02300	PARAMED ED PRGM	10,386	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	364	31.00
40.00	04000	SUBPROVIDER - IPF	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	41.00
42.00	04200	SUBPROVIDER	0	42.00
43.00	04300	NURSERY	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	44.00
45.00	04500	NURSING FACILITY	0	45.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0	50.00
51.00	05100	RECOVERY ROOM	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	380	52.00
53.00	05300	ANESTHESIOLOGY	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54.00
54.01	05401	ULTRASOUND	0	54.01
57.00	05700	CT SCAN	0	57.00
58.00	05800	MRI	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	59.00
60.00	06000	LABORATORY	0	60.00
60.01	06001	BLOOD LABORATORY	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	65.00
65.01	06501	SLEEP LAB	0	65.01
66.00	06600	PHYSICAL THERAPY	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	68.00
69.00	06900	ELECTROCARDIOLOGY	388	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73.00
74.00	07400	RENAL DIALYSIS	0	74.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	89.00
90.00	09000	CLINIC	0	90.00
90.01	09001	HOMER GLEN LAB	0	90.01
90.02	09002	HOMER GLEN FEC	0	90.02
90.03	09003	WOMEN'S HEALTH	0	90.03
91.00	09100	EMERGENCY	9,254	91.00
91.01	09101	OP MENTAL HEALTH	0	91.01
91.02	09102	DIABETES CENTER	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		92.00
		OTHER REIMBURSABLE COST CENTERS		
94.00	09400	HOME PROGRAM DIALYSIS	0	94.00
99.00	09900	CMHC	0	99.00
99.10	09910	CORF	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	101.00
		SPECIAL PURPOSE COST CENTERS		
109.00	10900	PANCREAS ACQUISITION	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	110.00
111.00	11100	ISLET ACQUISITION	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,386	118.00
		NONREIMBURSABLE COST CENTERS		
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet B-1 | Date/Time Prepared: 2/25/2019 3:00 pm

		Cost Center Description	PARAMED ED PRGM (ASSIGNED TIME)		
			23.00		
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		192.00
200.00		Cross Foot Adjustments			200.00
201.00		Negative Cost Centers			201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,144,862		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	110.231273		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	144,925		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	13.953880		205.00
206.00		NAHE adjustment amount to be allocated (per Wkst. B-2)	0		206.00
207.00		NAHE unit cost multiplier (Wkst. D, Parts III and IV)	0.000000		207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet C Part I Date/Time Prepared: 2/25/2019 3:00 pm

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		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	68,326,610		68,326,610	60,755	68,387,365	30.00
31.00	03100	INTENSIVE CARE UNIT	15,307,908		15,307,908	43,505	15,351,413	31.00
40.00	04000	SUBPROVIDER - IPF	5,203,986		5,203,986	11,918	5,215,904	40.00
41.00	04100	SUBPROVIDER - IRF	10,255,809		10,255,809	0	10,255,809	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	42.00
43.00	04300	NURSERY	9,501,657		9,501,657	0	9,501,657	43.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
45.00	04500	NURSING FACILITY	0		0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	40,130,101		40,130,101	0	40,130,101	50.00
51.00	05100	RECOVERY ROOM	2,840,639		2,840,639	0	2,840,639	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,338,617		7,338,617	0	7,338,617	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	28,783,609		28,783,609	26,706	28,810,315	54.00
54.01	05401	ULTRASOUND	2,981,465		2,981,465	0	2,981,465	54.01
57.00	05700	CT SCAN	4,285,376		4,285,376	0	4,285,376	57.00
58.00	05800	MRI	2,599,660		2,599,660	0	2,599,660	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	16,133,533		16,133,533	0	16,133,533	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,656,888		2,656,888	0	2,656,888	63.00
65.00	06500	RESPIRATORY THERAPY	3,686,859	0	3,686,859	0	3,686,859	65.00
65.01	06501	SLEEP LAB	671,266	0	671,266	0	671,266	65.01
66.00	06600	PHYSICAL THERAPY	3,345,606	0	3,345,606	0	3,345,606	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,439,657	0	3,439,657	0	3,439,657	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,761,626		2,761,626	16,998	2,778,624	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	494,562		494,562	20,886	515,448	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	20,211,248		20,211,248	0	20,211,248	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	27,207,178		27,207,178	0	27,207,178	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	24,805,583		24,805,583	0	24,805,583	73.00
74.00	07400	RENAL DIALYSIS	1,237,156		1,237,156	6,466	1,243,622	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000	CLINIC	1,179,796		1,179,796	1,376	1,181,172	90.00
90.01	09001	HOMER GLEN LAB	0		0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0		0	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0		0	0	0	90.03
91.00	09100	EMERGENCY	21,861,153		21,861,153	18,996	21,880,149	91.00
91.01	09101	OP MENTAL HEALTH	1,090,018		1,090,018	0	1,090,018	91.01
91.02	09102	DIABETES CENTER	400,134		400,134	744	400,878	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	11,891,101		11,891,101		11,891,101	92.00
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0		0	0	0	94.00
99.00	09900	CMHC	0		0		0	99.00
99.10	09910	CORF	0		0		0	99.10
101.00	10100	HOME HEALTH AGENCY	4,743,528		4,743,528		4,743,528	101.00
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0		0		0	109.00
110.00	11000	INTESTINAL ACQUISITION	0		0		0	110.00
111.00	11100	ISLET ACQUISITION	0		0		0	111.00
200.00		Subtotal (see instructions)	345,372,329	0	345,372,329	208,350	345,580,679	200.00
201.00		Less Observation Beds	11,891,101		11,891,101		11,891,101	201.00
202.00		Total (see instructions)	333,481,228	0	333,481,228	208,350	333,689,578	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet C Part I Date/Time Prepared: 2/25/2019 3:00 pm

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		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	62,747,189		62,747,189			30.00
31.00	03100	INTENSIVE CARE UNIT	19,753,519		19,753,519			31.00
40.00	04000	SUBPROVIDER - IPF	6,449,603		6,449,603			40.00
41.00	04100	SUBPROVIDER - IRF	16,767,847		16,767,847			41.00
42.00	04200	SUBPROVIDER	0		0			42.00
43.00	04300	NURSERY	9,411,792		9,411,792			43.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
45.00	04500	NURSING FACILITY	0		0			45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	52,478,178	88,912,029	141,390,207	0.283825	0.000000	50.00
51.00	05100	RECOVERY ROOM	15,486,651	14,384,489	29,871,140	0.095096	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,149,619	754,242	8,903,861	0.824206	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	42,979,953	132,905,956	175,885,909	0.163649	0.000000	54.00
54.01	05401	ULTRASOUND	8,935,484	22,194,985	31,130,469	0.095773	0.000000	54.01
57.00	05700	CT SCAN	34,246,315	88,725,876	122,972,191	0.034848	0.000000	57.00
58.00	05800	MRI	7,811,579	23,221,987	31,033,566	0.083769	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	64,599,515	118,348,978	182,948,493	0.088186	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	5,843,918	2,872,830	8,716,748	0.304803	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	10,772,290	2,407,511	13,179,801	0.279736	0.000000	65.00
65.01	06501	SLEEP LAB	0	3,525,988	3,525,988	0.190377	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	10,809,159	585,597	11,394,756	0.293609	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,439	9,591,386	9,594,825	0.358491	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	12,170,536	11,744,198	23,914,734	0.115478	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	570,300	2,082,939	2,653,239	0.186399	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	47,089,476	42,926,847	90,016,323	0.224529	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	31,157,066	14,730,786	45,887,852	0.592906	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	47,636,746	23,602,396	71,239,142	0.348202	0.000000	73.00
74.00	07400	RENAL DIALYSIS	3,810,693	369,648	4,180,341	0.295946	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0			88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			89.00
90.00	09000	CLINIC	495	1,129,073	1,129,568	1.044467	0.000000	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0.000000	0.000000	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0.000000	0.000000	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0	0.000000	0.000000	90.03
91.00	09100	EMERGENCY	29,500,042	73,582,136	103,082,178	0.212075	0.000000	91.00
91.01	09101	OP MENTAL HEALTH	0	1,683,199	1,683,199	0.647587	0.000000	91.01
91.02	09102	DIABETES CENTER	70,682	313,069	383,751	1.042692	0.000000	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,152,914	11,465,295	13,618,209	0.873177	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0.000000	0.000000	94.00
99.00	09900	CMHC	0	0	0			99.00
99.10	09910	CORF	0	0	0			99.10
101.00	10100	HOME HEALTH AGENCY	0	5,622,727	5,622,727			101.00
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0			109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0			110.00
111.00	11100	ISLET ACQUISITION	0	0	0			111.00
200.00		Subtotal (see instructions)	551,405,000	697,684,167	1,249,089,167			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	551,405,000	697,684,167	1,249,089,167			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet C Part I Date/Time Prepared: 2/25/2019 3:00 pm

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		Cost Center Description	PPS Inpatient Ratio
			11.00
		INPATIENT ROUTINE SERVICE COST CENTERS	
30.00	03000	ADULTS & PEDIATRICS	
31.00	03100	INTENSIVE CARE UNIT	
40.00	04000	SUBPROVIDER - IPF	
41.00	04100	SUBPROVIDER - IRF	
42.00	04200	SUBPROVIDER	
43.00	04300	NURSERY	
44.00	04400	SKILLED NURSING FACILITY	
45.00	04500	NURSING FACILITY	
		ANCILLARY SERVICE COST CENTERS	
50.00	05000	OPERATING ROOM	0.283825
51.00	05100	RECOVERY ROOM	0.095096
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.824206
53.00	05300	ANESTHESIOLOGY	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.163801
54.01	05401	ULTRASOUND	0.095773
57.00	05700	CT SCAN	0.034848
58.00	05800	MRI	0.083769
59.00	05900	CARDIAC CATHETERIZATION	0.000000
60.00	06000	LABORATORY	0.088186
60.01	06001	BLOOD LABORATORY	0.000000
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.304803
65.00	06500	RESPIRATORY THERAPY	0.279736
65.01	06501	SLEEP LAB	0.190377
66.00	06600	PHYSICAL THERAPY	0.293609
67.00	06700	OCCUPATIONAL THERAPY	0.358491
68.00	06800	SPEECH PATHOLOGY	0.000000
69.00	06900	ELECTROCARDIOLOGY	0.116189
70.00	07000	ELECTROENCEPHALOGRAPHY	0.194271
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.224529
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.592906
73.00	07300	DRUGS CHARGED TO PATIENTS	0.348202
74.00	07400	RENAL DIALYSIS	0.297493
		OUTPATIENT SERVICE COST CENTERS	
88.00	08800	RURAL HEALTH CLINIC	
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	
90.00	09000	CLINIC	1.045685
90.01	09001	HOMER GLEN LAB	0.000000
90.02	09002	HOMER GLEN FEC	0.000000
90.03	09003	WOMEN'S HEALTH	0.000000
91.00	09100	EMERGENCY	0.212259
91.01	09101	OP MENTAL HEALTH	0.647587
91.02	09102	DIABETES CENTER	1.044631
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.873177
		OTHER REIMBURSABLE COST CENTERS	
94.00	09400	HOME PROGRAM DIALYSIS	0.000000
99.00	09900	CMHC	
99.10	09910	CORF	
101.00	10100	HOME HEALTH AGENCY	
		SPECIAL PURPOSE COST CENTERS	
109.00	10900	PANCREAS ACQUISITION	
110.00	11000	INTESTINAL ACQUISITION	
111.00	11100	ISLET ACQUISITION	
200.00		Subtotal (see instructions)	
201.00		Less Observation Beds	
202.00		Total (see instructions)	

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet C Part I Date/Time Prepared: 2/25/2019 3:00 pm

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		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	68,326,610		68,326,610	60,755	68,387,365	30.00
31.00	03100	INTENSIVE CARE UNIT	15,307,908		15,307,908	43,505	15,351,413	31.00
40.00	04000	SUBPROVIDER - IPF	5,203,986		5,203,986	11,918	5,215,904	40.00
41.00	04100	SUBPROVIDER - IRF	10,255,809		10,255,809	0	10,255,809	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	42.00
43.00	04300	NURSERY	9,501,657		9,501,657	0	9,501,657	43.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
45.00	04500	NURSING FACILITY	0		0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	40,130,101		40,130,101	0	40,130,101	50.00
51.00	05100	RECOVERY ROOM	2,840,639		2,840,639	0	2,840,639	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,338,617		7,338,617	0	7,338,617	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	28,783,609		28,783,609	26,706	28,810,315	54.00
54.01	05401	ULTRASOUND	2,981,465		2,981,465	0	2,981,465	54.01
57.00	05700	CT SCAN	4,285,376		4,285,376	0	4,285,376	57.00
58.00	05800	MRI	2,599,660		2,599,660	0	2,599,660	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	16,133,533		16,133,533	0	16,133,533	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,656,888		2,656,888	0	2,656,888	63.00
65.00	06500	RESPIRATORY THERAPY	3,686,859	0	3,686,859	0	3,686,859	65.00
65.01	06501	SLEEP LAB	671,266	0	671,266	0	671,266	65.01
66.00	06600	PHYSICAL THERAPY	3,345,606	0	3,345,606	0	3,345,606	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,439,657	0	3,439,657	0	3,439,657	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,761,626		2,761,626	16,998	2,778,624	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	494,562		494,562	20,886	515,448	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	20,211,248		20,211,248	0	20,211,248	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	27,207,178		27,207,178	0	27,207,178	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	24,805,583		24,805,583	0	24,805,583	73.00
74.00	07400	RENAL DIALYSIS	1,237,156		1,237,156	6,466	1,243,622	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000	CLINIC	1,179,796		1,179,796	1,376	1,181,172	90.00
90.01	09001	HOMER GLEN LAB	0		0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0		0	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0		0	0	0	90.03
91.00	09100	EMERGENCY	21,861,153		21,861,153	18,996	21,880,149	91.00
91.01	09101	OP MENTAL HEALTH	1,090,018		1,090,018	0	1,090,018	91.01
91.02	09102	DIABETES CENTER	400,134		400,134	744	400,878	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	11,891,101		11,891,101		11,891,101	92.00
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0		0	0	0	94.00
99.00	09900	CMHC	0		0		0	99.00
99.10	09910	CORF	0		0		0	99.10
101.00	10100	HOME HEALTH AGENCY	4,743,528		4,743,528		4,743,528	101.00
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0		0		0	109.00
110.00	11000	INTESTINAL ACQUISITION	0		0		0	110.00
111.00	11100	ISLET ACQUISITION	0		0		0	111.00
200.00		Subtotal (see instructions)	345,372,329	0	345,372,329	208,350	345,580,679	200.00
201.00		Less Observation Beds	11,891,101		11,891,101		11,891,101	201.00
202.00		Total (see instructions)	333,481,228	0	333,481,228	208,350	333,689,578	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet C Part I Date/Time Prepared: 2/25/2019 3:00 pm

Title XIX | 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	62,747,189		62,747,189			30.00
31.00	03100	INTENSIVE CARE UNIT	19,753,519		19,753,519			31.00
40.00	04000	SUBPROVIDER - IPF	6,449,603		6,449,603			40.00
41.00	04100	SUBPROVIDER - IRF	16,767,847		16,767,847			41.00
42.00	04200	SUBPROVIDER	0		0			42.00
43.00	04300	NURSERY	9,411,792		9,411,792			43.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
45.00	04500	NURSING FACILITY	0		0			45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	52,478,178	88,912,029	141,390,207	0.283825	0.000000	50.00
51.00	05100	RECOVERY ROOM	15,486,651	14,384,489	29,871,140	0.095096	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,149,619	754,242	8,903,861	0.824206	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	42,979,953	132,905,956	175,885,909	0.163649	0.000000	54.00
54.01	05401	ULTRASOUND	8,935,484	22,194,985	31,130,469	0.095773	0.000000	54.01
57.00	05700	CT SCAN	34,246,315	88,725,876	122,972,191	0.034848	0.000000	57.00
58.00	05800	MRI	7,811,579	23,221,987	31,033,566	0.083769	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	64,599,515	118,348,978	182,948,493	0.088186	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	5,843,918	2,872,830	8,716,748	0.304803	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	10,772,290	2,407,511	13,179,801	0.279736	0.000000	65.00
65.01	06501	SLEEP LAB	0	3,525,988	3,525,988	0.190377	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	10,809,159	585,597	11,394,756	0.293609	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,439	9,591,386	9,594,825	0.358491	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	12,170,536	11,744,198	23,914,734	0.115478	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	570,300	2,082,939	2,653,239	0.186399	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	47,089,476	42,926,847	90,016,323	0.224529	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	31,157,066	14,730,786	45,887,852	0.592906	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	47,636,746	23,602,396	71,239,142	0.348202	0.000000	73.00
74.00	07400	RENAL DIALYSIS	3,810,693	369,648	4,180,341	0.295946	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0.000000	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	0.000000	89.00
90.00	09000	CLINIC	495	1,129,073	1,129,568	1.044467	0.000000	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0.000000	0.000000	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0.000000	0.000000	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0	0.000000	0.000000	90.03
91.00	09100	EMERGENCY	29,500,042	73,582,136	103,082,178	0.212075	0.000000	91.00
91.01	09101	OP MENTAL HEALTH	0	1,683,199	1,683,199	0.647587	0.000000	91.01
91.02	09102	DIABETES CENTER	70,682	313,069	383,751	1.042692	0.000000	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,152,914	11,465,295	13,618,209	0.873177	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0.000000	0.000000	94.00
99.00	09900	CMHC	0	0	0			99.00
99.10	09910	CORF	0	0	0			99.10
101.00	10100	HOME HEALTH AGENCY	0	5,622,727	5,622,727			101.00
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0			109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0			110.00
111.00	11100	ISLET ACQUISITION	0	0	0			111.00
200.00		Subtotal (see instructions)	551,405,000	697,684,167	1,249,089,167			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	551,405,000	697,684,167	1,249,089,167			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet C Part I Date/Time Prepared: 2/25/2019 3:00 pm

Title XIX | 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
42.00	04200	SUBPROVIDER			42.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
45.00	04500	NURSING FACILITY			45.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.283825		50.00
51.00	05100	RECOVERY ROOM	0.095096		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.824206		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.163801		54.00
54.01	05401	ULTRASOUND	0.095773		54.01
57.00	05700	CT SCAN	0.034848		57.00
58.00	05800	MRI	0.083769		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.088186		60.00
60.01	06001	BLOOD LABORATORY	0.000000		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.304803		63.00
65.00	06500	RESPIRATORY THERAPY	0.279736		65.00
65.01	06501	SLEEP LAB	0.190377		65.01
66.00	06600	PHYSICAL THERAPY	0.293609		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.358491		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.116189		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.194271		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.224529		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.592906		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.348202		73.00
74.00	07400	RENAL DIALYSIS	0.297493		74.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
90.00	09000	CLINIC	1.045685		90.00
90.01	09001	HOMER GLEN LAB	0.000000		90.01
90.02	09002	HOMER GLEN FEC	0.000000		90.02
90.03	09003	WOMEN'S HEALTH	0.000000		90.03
91.00	09100	EMERGENCY	0.212259		91.00
91.01	09101	OP MENTAL HEALTH	0.647587		91.01
91.02	09102	DIABETES CENTER	1.044631		91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.873177		92.00
		OTHER REIMBURSABLE COST CENTERS			
94.00	09400	HOME PROGRAM DIALYSIS	0.000000		94.00
99.00	09900	CMHC			99.00
99.10	09910	CORF			99.10
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
109.00	10900	PANCREAS ACQUISITION			109.00
110.00	11000	INTESTINAL ACQUISITION			110.00
111.00	11100	ISLET ACQUISITION			111.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

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

Provider CCN: 14-0213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet C Part II Date/Time Prepared: 2/25/2019 3:00 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	40,130,101	6,445,434	33,684,667	0	0	50.00
51.00	05100	RECOVERY ROOM	2,840,639	346,083	2,494,556	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,338,617	662,597	6,676,020	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	28,783,609	4,858,600	23,925,009	0	0	54.00
54.01	05401	ULTRASOUND	2,981,465	468,295	2,513,170	0	0	54.01
57.00	05700	CT SCAN	4,285,376	804,070	3,481,306	0	0	57.00
58.00	05800	MRI	2,599,660	585,509	2,014,151	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	16,133,533	899,130	15,234,403	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,656,888	120,905	2,535,983	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	3,686,859	307,013	3,379,846	0	0	65.00
65.01	06501	SLEEP LAB	671,266	62,296	608,970	0	0	65.01
66.00	06600	PHYSICAL THERAPY	3,345,606	172,668	3,172,938	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,439,657	158,572	3,281,085	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,761,626	269,009	2,492,617	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	494,562	76,667	417,895	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	20,211,248	1,313,028	18,898,220	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	27,207,178	1,098,247	26,108,931	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	24,805,583	1,330,325	23,475,258	0	0	73.00
74.00	07400	RENAL DIALYSIS	1,237,156	217,262	1,019,894	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	1,179,796	54,285	1,125,511	0	0	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	21,861,153	2,778,406	19,082,747	0	0	91.00
91.01	09101	OP MENTAL HEALTH	1,090,018	178,002	912,016	0	0	91.01
91.02	09102	DIABETES CENTER	400,134	18,427	381,707	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	11,891,101	1,585,001	10,306,100	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	4,743,528	204,282	4,539,246	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
200.00		Subtotal (sum of lines 50 thru 199)	236,776,359	25,014,113	211,762,246	0	0	200.00
201.00		Less Observation Beds	11,891,101	1,585,001	10,306,100	0	0	201.00
202.00		Total (line 200 minus line 201)	224,885,258	23,429,112	201,456,146	0	0	202.00

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

Provider CCN: 14-0213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet C Part II Date/Time Prepared: 2/25/2019 3:00 pm

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	40,130,101	141,390,207	0.283825		50.00
51.00	05100	RECOVERY ROOM	2,840,639	29,871,140	0.095096		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,338,617	8,903,861	0.824206		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	28,783,609	175,885,909	0.163649		54.00
54.01	05401	ULTRASOUND	2,981,465	31,130,469	0.095773		54.01
57.00	05700	CT SCAN	4,285,376	122,972,191	0.034848		57.00
58.00	05800	MRI	2,599,660	31,033,566	0.083769		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000		59.00
60.00	06000	LABORATORY	16,133,533	182,948,493	0.088186		60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,656,888	8,716,748	0.304803		63.00
65.00	06500	RESPIRATORY THERAPY	3,686,859	13,179,801	0.279736		65.00
65.01	06501	SLEEP LAB	671,266	3,525,988	0.190377		65.01
66.00	06600	PHYSICAL THERAPY	3,345,606	11,394,756	0.293609		66.00
67.00	06700	OCCUPATIONAL THERAPY	3,439,657	9,594,825	0.358491		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	2,761,626	23,914,734	0.115478		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	494,562	2,653,239	0.186399		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	20,211,248	90,016,323	0.224529		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	27,207,178	45,887,852	0.592906		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	24,805,583	71,239,142	0.348202		73.00
74.00	07400	RENAL DIALYSIS	1,237,156	4,180,341	0.295946		74.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000		89.00
90.00	09000	CLINIC	1,179,796	1,129,568	1.044467		90.00
90.01	09001	HOMER GLEN LAB	0	0	0.000000		90.01
90.02	09002	HOMER GLEN FEC	0	0	0.000000		90.02
90.03	09003	WOMEN'S HEALTH	0	0	0.000000		90.03
91.00	09100	EMERGENCY	21,861,153	103,082,178	0.212075		91.00
91.01	09101	OP MENTAL HEALTH	1,090,018	1,683,199	0.647587		91.01
91.02	09102	DIABETES CENTER	400,134	383,751	1.042692		91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	11,891,101	13,618,209	0.873177		92.00
		OTHER REIMBURSABLE COST CENTERS					
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0.000000		94.00
99.00	09900	CMHC	0	0	0.000000		99.00
99.10	09910	CORF	0	0	0.000000		99.10
101.00	10100	HOME HEALTH AGENCY	4,743,528	5,622,727	0.843635		101.00
		SPECIAL PURPOSE COST CENTERS					
109.00	10900	PANCREAS ACQUISITION	0	0	0.000000		109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0.000000		110.00
111.00	11100	ISLET ACQUISITION	0	0	0.000000		111.00
200.00		Subtotal (sum of lines 50 thru 199)	236,776,359	1,133,959,217			200.00
201.00		Less Observation Beds	11,891,101	0			201.00
202.00		Total (line 200 minus line 201)	224,885,258	1,133,959,217			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 14-0213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part I Date/Time Prepared: 2/25/2019 3:00 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	9,115,584	0	9,115,584	67,622	134.80	30.00
31.00	INTENSIVE CARE UNIT	1,865,334		1,865,334	7,381	252.72	31.00
40.00	SUBPROVIDER - IPF	773,780	0	773,780	5,739	134.83	40.00
41.00	SUBPROVIDER - IRF	1,488,914	0	1,488,914	8,099	183.84	41.00
42.00	SUBPROVIDER	0	0	0	0	0.00	42.00
43.00	NURSERY	2,568,264		2,568,264	6,959	369.06	43.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
45.00	NURSING FACILITY	0		0	0	0.00	45.00
200.00	Total (lines 30 through 199)	15,811,876		15,811,876	95,800		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	25,441	3,429,447	30.00
31.00	INTENSIVE CARE UNIT	3,266	825,384	31.00
40.00	SUBPROVIDER - IPF	989	133,347	40.00
41.00	SUBPROVIDER - IRF	5,757	1,058,367	41.00
42.00	SUBPROVIDER	0	0	42.00
43.00	NURSERY	0	0	43.00
44.00	SKILLED NURSING FACILITY	0	0	44.00
45.00	NURSING FACILITY	0	0	45.00
200.00	Total (lines 30 through 199)	35,453	5,446,545	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-0213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part II Date/Time Prepared: 2/25/2019 3:00 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	6,445,434	141,390,207	0.045586	19,763,850	900,955	50.00
51.00	05100	RECOVERY ROOM	346,083	29,871,140	0.011586	4,029,994	46,692	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	662,597	8,903,861	0.074417	13,379	996	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,858,600	175,885,909	0.027624	16,960,073	468,505	54.00
54.01	05401	ULTRASOUND	468,295	31,130,469	0.015043	4,287,084	64,491	54.01
57.00	05700	CT SCAN	804,070	122,972,191	0.006539	17,464,365	114,199	57.00
58.00	05800	MRI	585,509	31,033,566	0.018867	3,898,266	73,549	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	899,130	182,948,493	0.004915	28,680,768	140,966	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	120,905	8,716,748	0.013870	2,312,177	32,070	63.00
65.00	06500	RESPIRATORY THERAPY	307,013	13,179,801	0.023294	6,315,918	147,123	65.00
65.01	06501	SLEEP LAB	62,296	3,525,988	0.017668	0	0	65.01
66.00	06600	PHYSICAL THERAPY	172,668	11,394,756	0.015153	2,931,724	44,424	66.00
67.00	06700	OCCUPATIONAL THERAPY	158,572	9,594,825	0.016527	522	9	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	269,009	23,914,734	0.011249	6,501,363	73,134	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	76,667	2,653,239	0.028896	292,818	8,461	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,313,028	90,016,323	0.014587	16,738,955	244,171	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,098,247	45,887,852	0.023933	12,762,082	305,435	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,330,325	71,239,142	0.018674	16,596,363	309,920	73.00
74.00	07400	RENAL DIALYSIS	217,262	4,180,341	0.051972	2,240,449	116,441	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	54,285	1,129,568	0.048058	362	17	90.00
90.01	09001	HOMER GLEN LAB	0	0	0.000000	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0.000000	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0.000000	0	0	90.03
91.00	09100	EMERGENCY	2,778,406	103,082,178	0.026953	13,358,226	360,044	91.00
91.01	09101	OP MENTAL HEALTH	178,002	1,683,199	0.105752	0	0	91.01
91.02	09102	DIABETES CENTER	18,427	383,751	0.048018	19,106	917	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,585,001	13,618,209	0.116388	964,312	112,234	92.00
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0.000000	0	0	94.00
200.00		Total (lines 50 through 199)	24,809,831	1,128,336,490		176,132,156	3,564,753	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part III Date/Time Prepared: 2/25/2019 3:00 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	40,124	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
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0		44.00
45.00	04500	NURSING FACILITY	0	0	0	0		45.00
200.00		Total (lines 30 through 199)	0	0	0	40,124	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	67,622	0.00	25,441	30.00
31.00	03100	INTENSIVE CARE UNIT		40,124	7,381	5.44	3,266	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	5,739	0.00	989	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	8,099	0.00	5,757	41.00
42.00	04200	SUBPROVIDER	0	0	0	0.00	0	42.00
43.00	04300	NURSERY		0	6,959	0.00	0	43.00
44.00	04400	SKILLED NURSING FACILITY		0	0	0.00	0	44.00
45.00	04500	NURSING FACILITY		0	0	0.00	0	45.00
200.00		Total (lines 30 through 199)		40,124	95,800		35,453	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	17,767	31.00
40.00	04000	SUBPROVIDER - IPF	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	41.00
42.00	04200	SUBPROVIDER	0	42.00
43.00	04300	NURSERY	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	44.00
45.00	04500	NURSING FACILITY	0	45.00
200.00		Total (lines 30 through 199)	17,767	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part IV Date/Time Prepared: 2/25/2019 3:00 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	41,888	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
65.01	06501	SLEEP LAB	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	42,770	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	0	0	1,020,080	91.00
91.01	09101	OP MENTAL HEALTH	0	0	0	0	0	91.01
91.02	09102	DIABETES CENTER	0	0	0	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
200.00		Total (lines 50 through 199)	0	0	0	0	1,104,738	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part IV Date/Time Prepared: 2/25/2019 3:00 pm

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	141,390,207	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	29,871,140	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	41,888	41,888	8,903,861	0.004704	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	175,885,909	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	31,130,469	0.000000	54.01
57.00	05700	CT SCAN	0	0	0	122,972,191	0.000000	57.00
58.00	05800	MRI	0	0	0	31,033,566	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	182,948,493	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	8,716,748	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	13,179,801	0.000000	65.00
65.01	06501	SLEEP LAB	0	0	0	3,525,988	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	11,394,756	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	9,594,825	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	42,770	42,770	23,914,734	0.001788	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	2,653,239	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	90,016,323	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	45,887,852	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	71,239,142	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	4,180,341	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000	89.00
90.00	09000	CLINIC	0	0	0	1,129,568	0.000000	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	0.000000	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	0.000000	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0	0	0.000000	90.03
91.00	09100	EMERGENCY	0	1,020,080	1,020,080	103,082,178	0.009896	91.00
91.01	09101	OP MENTAL HEALTH	0	0	0	1,683,199	0.000000	91.01
91.02	09102	DIABETES CENTER	0	0	0	383,751	0.000000	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	13,618,209	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0.000000	94.00
200.00		Total (lines 50 through 199)	0	1,104,738	1,104,738	1,128,336,490		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part IV Date/Time Prepared: 2/25/2019 3:00 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	19,763,850	0	20,613,093	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	4,029,994	0	2,706,827	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.004704	13,379	63	953	4	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	16,960,073	0	44,733,821	0	54.00
54.01	05401	ULTRASOUND	0.000000	4,287,084	0	4,012,718	0	54.01
57.00	05700	CT SCAN	0.000000	17,464,365	0	23,057,347	0	57.00
58.00	05800	MRI	0.000000	3,898,266	0	12,503,492	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	28,680,768	0	12,489,224	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	2,312,177	0	811,518	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	6,315,918	0	558,976	0	65.00
65.01	06501	SLEEP LAB	0.000000	0	0	944,964	0	65.01
66.00	06600	PHYSICAL THERAPY	0.000000	2,931,724	0	52,263	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	522	0	149,915	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.001788	6,501,363	11,624	3,308,215	5,915	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	292,818	0	548,792	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	16,738,955	0	9,982,679	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	12,762,082	0	4,680,659	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	16,596,363	0	1,415,438	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	2,240,449	0	150,587	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	89.00
90.00	09000	CLINIC	0.000000	362	0	472,336	0	90.00
90.01	09001	HOMER GLEN LAB	0.000000	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0.000000	0	0	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0.000000	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.009896	13,358,226	132,193	11,548,830	114,287	91.00
91.01	09101	OP MENTAL HEALTH	0.000000	0	0	123,355	0	91.01
91.02	09102	DIABETES CENTER	0.000000	19,106	0	35,931	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	964,312	0	3,285,356	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0.000000	0	0	0	0	94.00
200.00		Total (lines 50 through 199)		176,132,156	143,880	158,187,289	120,206	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part V Date/Time Prepared: 2/25/2019 3:00 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	0.283825	20,613,093	16	0	5,850,511	50.00
51.00	05100	RECOVERY ROOM	0.095096	2,706,827	1,857	0	257,408	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.824206	953	0	0	785	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.163649	44,733,821	4,938	3,487	7,320,645	54.00
54.01	05401	ULTRASOUND	0.095773	4,012,718	0	0	384,310	54.01
57.00	05700	CT SCAN	0.034848	23,057,347	5,630	0	803,502	57.00
58.00	05800	MRI	0.083769	12,503,492	4,566	52,406	1,047,405	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.088186	12,489,224	3,291	0	1,101,375	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.304803	811,518	6	0	247,353	63.00
65.00	06500	RESPIRATORY THERAPY	0.279736	558,976	130	0	156,366	65.00
65.01	06501	SLEEP LAB	0.190377	944,964	0	0	179,899	65.01
66.00	06600	PHYSICAL THERAPY	0.293609	52,263	85	0	15,345	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.358491	149,915	420	0	53,743	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.115478	3,308,215	1,543	0	382,026	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.186399	548,792	0	0	102,294	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.224529	9,982,679	8,974	50	2,241,401	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.592906	4,680,659	43,099	0	2,775,191	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.348202	1,415,438	425	0	492,858	73.00
74.00	07400	RENAL DIALYSIS	0.295946	150,587	0	0	44,566	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
90.00	09000	CLINIC	1.044467	472,336	0	0	493,339	90.00
90.01	09001	HOMER GLEN LAB	0.000000	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0.000000	0	0	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0.000000	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.212075	11,548,830	3,849	133	2,449,218	91.00
91.01	09101	OP MENTAL HEALTH	0.647587	123,355	0	0	79,883	91.01
91.02	09102	DIABETES CENTER	1.042692	35,931	0	0	37,465	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.873177	3,285,356	5,616	0	2,868,697	92.00
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0.000000		0			94.00
200.00		Subtotal (see instructions)		158,187,289	84,445	56,076	29,385,585	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		158,187,289	84,445	56,076	29,385,585	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part V Date/Time Prepared: 2/25/2019 3:00 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	5	0		50.00
51.00	05100	RECOVERY ROOM	177	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	808	571		54.00
54.01	05401	ULTRASOUND	0	0		54.01
57.00	05700	CT SCAN	196	0		57.00
58.00	05800	MRI	382	4,390		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	290	0		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2	0		63.00
65.00	06500	RESPIRATORY THERAPY	36	0		65.00
65.01	06501	SLEEP LAB	0	0		65.01
66.00	06600	PHYSICAL THERAPY	25	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	151	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	178	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,015	11		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	25,554	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	148	0		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	HOMER GLEN LAB	0	0		90.01
90.02	09002	HOMER GLEN FEC	0	0		90.02
90.03	09003	WOMEN'S HEALTH	0	0		90.03
91.00	09100	EMERGENCY	816	28		91.00
91.01	09101	OP MENTAL HEALTH	0	0		91.01
91.02	09102	DIABETES CENTER	0	0		91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	4,904	0		92.00
		OTHER REIMBURSABLE COST CENTERS				
94.00	09400	HOME PROGRAM DIALYSIS	0	0		94.00
200.00		Subtotal (see instructions)	35,687	5,000		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 - line 201)	35,687	5,000		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0213 | Component CCN: 14-S213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part II | Date/Time Prepared: 2/25/2019 3:00 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	6,445,434	141,390,207	0.045586	31	1	50.00
51.00	05100	RECOVERY ROOM	346,083	29,871,140	0.011586	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	662,597	8,903,861	0.074417	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,858,600	175,885,909	0.027624	7,703	213	54.00
54.01	05401	ULTRASOUND	468,295	31,130,469	0.015043	6,406	96	54.01
57.00	05700	CT SCAN	804,070	122,972,191	0.006539	19,826	130	57.00
58.00	05800	MRI	585,509	31,033,566	0.018867	5,882	111	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	899,130	182,948,493	0.004915	209,033	1,027	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	120,905	8,716,748	0.013870	4,434	61	63.00
65.00	06500	RESPIRATORY THERAPY	307,013	13,179,801	0.023294	15,232	355	65.00
65.01	06501	SLEEP LAB	62,296	3,525,988	0.017668	0	0	65.01
66.00	06600	PHYSICAL THERAPY	172,668	11,394,756	0.015153	3,888	59	66.00
67.00	06700	OCCUPATIONAL THERAPY	158,572	9,594,825	0.016527	1	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	269,009	23,914,734	0.011249	6,744	76	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	76,667	2,653,239	0.028896	833	24	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,313,028	90,016,323	0.014587	6,610	96	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,098,247	45,887,852	0.023933	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,330,325	71,239,142	0.018674	18,740	350	73.00
74.00	07400	RENAL DIALYSIS	217,262	4,180,341	0.051972	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	54,285	1,129,568	0.048058	0	0	90.00
90.01	09001	HOMER GLEN LAB	0	0	0.000000	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0.000000	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0.000000	0	0	90.03
91.00	09100	EMERGENCY	2,778,406	103,082,178	0.026953	184,488	4,973	91.00
91.01	09101	OP MENTAL HEALTH	178,002	1,683,199	0.105752	0	0	91.01
91.02	09102	DIABETES CENTER	18,427	383,751	0.048018	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	13,618,209	0.000000	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0.000000	0	0	94.00
200.00		Total (lines 50 through 199)	23,224,830	1,128,336,490		489,851	7,572	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0213 | Component CCN: 14-S213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part IV Date/Time Prepared: 2/25/2019 3:00 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	41,888	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
65.01	06501	SLEEP LAB	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	42,770	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	0	0	1,020,080	91.00
91.01	09101	OP MENTAL HEALTH	0	0	0	0	0	91.01
91.02	09102	DIABETES CENTER	0	0	0	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
200.00		Total (lines 50 through 199)	0	0	0	0	1,104,738	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0213 | Component CCN: 14-S213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part IV | Date/Time Prepared: 2/25/2019 3:00 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	141,390,207	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	29,871,140	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	41,888	41,888	8,903,861	0.004704	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	175,885,909	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	31,130,469	0.000000	54.01
57.00	05700	CT SCAN	0	0	0	122,972,191	0.000000	57.00
58.00	05800	MRI	0	0	0	31,033,566	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	182,948,493	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	8,716,748	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	13,179,801	0.000000	65.00
65.01	06501	SLEEP LAB	0	0	0	3,525,988	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	11,394,756	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	9,594,825	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	42,770	42,770	23,914,734	0.001788	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	2,653,239	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	90,016,323	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	45,887,852	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	71,239,142	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	4,180,341	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000	89.00
90.00	09000	CLINIC	0	0	0	1,129,568	0.000000	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	0.000000	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	0.000000	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0	0	0.000000	90.03
91.00	09100	EMERGENCY	0	1,020,080	1,020,080	103,082,178	0.009896	91.00
91.01	09101	OP MENTAL HEALTH	0	0	0	1,683,199	0.000000	91.01
91.02	09102	DIABETES CENTER	0	0	0	383,751	0.000000	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	13,618,209	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0.000000	94.00
200.00		Total (lines 50 through 199)	0	1,104,738	1,104,738	1,128,336,490		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0213 | Component CCN: 14-S213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part IV | Date/Time Prepared: 2/25/2019 3:00 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	31	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	0.004704	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	7,703	0	0	0	54.00
54.01	05401	ULTRASOUND	0.000000	6,406	0	0	0	54.01
57.00	05700	CT SCAN	0.000000	19,826	0	0	0	57.00
58.00	05800	MRI	0.000000	5,882	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	209,033	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	4,434	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	15,232	0	0	0	65.00
65.01	06501	SLEEP LAB	0.000000	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.000000	3,888	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	1	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.001788	6,744	12	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	833	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	6,610	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	18,740	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	89.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	HOMER GLEN LAB	0.000000	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0.000000	0	0	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0.000000	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.009896	184,488	1,826	0	0	91.00
91.01	09101	OP MENTAL HEALTH	0.000000	0	0	0	0	91.01
91.02	09102	DIABETES CENTER	0.000000	0	0	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0.000000	0	0	0	0	94.00
200.00		Total (lines 50 through 199)		489,851	1,838	0	0	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0213 | Component CCN: 14-T213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part II | Date/Time Prepared: 2/25/2019 3:00 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	6,445,434	141,390,207	0.045586	1,849	84	50.00
51.00	05100	RECOVERY ROOM	346,083	29,871,140	0.011586	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	662,597	8,903,861	0.074417	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,858,600	175,885,909	0.027624	147,903	4,086	54.00
54.01	05401	ULTRASOUND	468,295	31,130,469	0.015043	95,729	1,440	54.01
57.00	05700	CT SCAN	804,070	122,972,191	0.006539	250,808	1,640	57.00
58.00	05800	MRI	585,509	31,033,566	0.018867	76,090	1,436	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	899,130	182,948,493	0.004915	1,405,773	6,909	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	120,905	8,716,748	0.013870	45,959	637	63.00
65.00	06500	RESPIRATORY THERAPY	307,013	13,179,801	0.023294	299,606	6,979	65.00
65.01	06501	SLEEP LAB	62,296	3,525,988	0.017668	0	0	65.01
66.00	06600	PHYSICAL THERAPY	172,668	11,394,756	0.015153	2,395,749	36,303	66.00
67.00	06700	OCCUPATIONAL THERAPY	158,572	9,594,825	0.016527	307	5	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	269,009	23,914,734	0.011249	60,195	677	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	76,667	2,653,239	0.028896	4,583	132	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,313,028	90,016,323	0.014587	377,798	5,511	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,098,247	45,887,852	0.023933	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,330,325	71,239,142	0.018674	538,973	10,065	73.00
74.00	07400	RENAL DIALYSIS	217,262	4,180,341	0.051972	255,821	13,296	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	54,285	1,129,568	0.048058	0	0	90.00
90.01	09001	HOMER GLEN LAB	0	0	0.000000	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0.000000	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0.000000	0	0	90.03
91.00	09100	EMERGENCY	2,778,406	103,082,178	0.026953	476	13	91.00
91.01	09101	OP MENTAL HEALTH	178,002	1,683,199	0.105752	0	0	91.01
91.02	09102	DIABETES CENTER	18,427	383,751	0.048018	1,923	92	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	13,618,209	0.000000	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0.000000	0	0	94.00
200.00		Total (lines 50 through 199)	23,224,830	1,128,336,490		5,959,542	89,305	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0213 | Component CCN: 14-T213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part IV Date/Time Prepared: 2/25/2019 3:00 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	41,888	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
65.01	06501	SLEEP LAB	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	42,770	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	0	0	1,020,080	91.00
91.01	09101	OP MENTAL HEALTH	0	0	0	0	0	91.01
91.02	09102	DIABETES CENTER	0	0	0	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
200.00		Total (lines 50 through 199)	0	0	0	0	1,104,738	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0213 | Component CCN: 14-T213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part IV | Date/Time Prepared: 2/25/2019 3:00 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	141,390,207	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	29,871,140	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	41,888	41,888	8,903,861	0.004704	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	175,885,909	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	31,130,469	0.000000	54.01
57.00	05700	CT SCAN	0	0	0	122,972,191	0.000000	57.00
58.00	05800	MRI	0	0	0	31,033,566	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	182,948,493	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	8,716,748	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	13,179,801	0.000000	65.00
65.01	06501	SLEEP LAB	0	0	0	3,525,988	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	11,394,756	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	9,594,825	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	42,770	42,770	23,914,734	0.001788	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	2,653,239	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	90,016,323	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	45,887,852	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	71,239,142	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	4,180,341	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000	89.00
90.00	09000	CLINIC	0	0	0	1,129,568	0.000000	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	0.000000	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	0.000000	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0	0	0.000000	90.03
91.00	09100	EMERGENCY	0	1,020,080	1,020,080	103,082,178	0.009896	91.00
91.01	09101	OP MENTAL HEALTH	0	0	0	1,683,199	0.000000	91.01
91.02	09102	DIABETES CENTER	0	0	0	383,751	0.000000	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	13,618,209	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0.000000	94.00
200.00		Total (lines 50 through 199)	0	1,104,738	1,104,738	1,128,336,490		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0213 | Component CCN: 14-T213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part IV Date/Time Prepared: 2/25/2019 3:00 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	1,849	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	0.004704	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	147,903	0	0	0	54.00
54.01	05401	ULTRASOUND	0.000000	95,729	0	0	0	54.01
57.00	05700	CT SCAN	0.000000	250,808	0	0	0	57.00
58.00	05800	MRI	0.000000	76,090	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	1,405,773	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	45,959	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	299,606	0	0	0	65.00
65.01	06501	SLEEP LAB	0.000000	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.000000	2,395,749	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	307	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.001788	60,195	108	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	4,583	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	377,798	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	538,973	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	255,821	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	89.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	HOMER GLEN LAB	0.000000	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0.000000	0	0	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0.000000	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.009896	476	5	0	0	91.00
91.01	09101	OP MENTAL HEALTH	0.000000	0	0	0	0	91.01
91.02	09102	DIABETES CENTER	0.000000	1,923	0	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0.000000	0	0	0	0	94.00
200.00		Total (lines 50 through 199)		5,959,542	113	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 14-0213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part I Date/Time Prepared: 2/25/2019 3:00 pm

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	9,115,584	0	9,115,584	67,622	134.80	30.00
31.00	INTENSIVE CARE UNIT	1,865,334		1,865,334	7,381	252.72	31.00
40.00	SUBPROVIDER - IPF	773,780	0	773,780	5,739	134.83	40.00
41.00	SUBPROVIDER - IRF	1,488,914	0	1,488,914	8,099	183.84	41.00
42.00	SUBPROVIDER	0	0	0	0	0.00	42.00
43.00	NURSERY	2,568,264		2,568,264	6,959	369.06	43.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
45.00	NURSING FACILITY	0		0	0	0.00	45.00
200.00	Total (lines 30 through 199)	15,811,876		15,811,876	95,800		200.00

	Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
	INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	ADULTS & PEDIATRICS	3,760	506,848	30.00
31.00	INTENSIVE CARE UNIT	522	131,920	31.00
40.00	SUBPROVIDER - IPF	708	95,460	40.00
41.00	SUBPROVIDER - IRF	96	17,649	41.00
42.00	SUBPROVIDER	0	0	42.00
43.00	NURSERY	465	171,613	43.00
44.00	SKILLED NURSING FACILITY	0	0	44.00
45.00	NURSING FACILITY	0	0	45.00
200.00	Total (lines 30 through 199)	5,551	923,490	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-0213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part II Date/Time Prepared: 2/25/2019 3:00 pm

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,445,434	141,390,207	0.045586	0	0	50.00
51.00	05100	RECOVERY ROOM	346,083	29,871,140	0.011586	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	662,597	8,903,861	0.074417	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,858,600	175,885,909	0.027624	0	0	54.00
54.01	05401	ULTRASOUND	468,295	31,130,469	0.015043	0	0	54.01
57.00	05700	CT SCAN	804,070	122,972,191	0.006539	0	0	57.00
58.00	05800	MRI	585,509	31,033,566	0.018867	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	899,130	182,948,493	0.004915	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	120,905	8,716,748	0.013870	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	307,013	13,179,801	0.023294	0	0	65.00
65.01	06501	SLEEP LAB	62,296	3,525,988	0.017668	0	0	65.01
66.00	06600	PHYSICAL THERAPY	172,668	11,394,756	0.015153	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	158,572	9,594,825	0.016527	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	269,009	23,914,734	0.011249	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	76,667	2,653,239	0.028896	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,313,028	90,016,323	0.014587	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,098,247	45,887,852	0.023933	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,330,325	71,239,142	0.018674	0	0	73.00
74.00	07400	RENAL DIALYSIS	217,262	4,180,341	0.051972	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	54,285	1,129,568	0.048058	0	0	90.00
90.01	09001	HOMER GLEN LAB	0	0	0.000000	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0.000000	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0.000000	0	0	90.03
91.00	09100	EMERGENCY	2,778,406	103,082,178	0.026953	0	0	91.00
91.01	09101	OP MENTAL HEALTH	178,002	1,683,199	0.105752	0	0	91.01
91.02	09102	DIABETES CENTER	18,427	383,751	0.048018	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,585,001	13,618,209	0.116388	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0.000000	0	0	94.00
200.00		Total (lines 50 through 199)	24,809,831	1,128,336,490		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part III Date/Time Prepared: 2/25/2019 3:00 pm

Title XIX | Hospital | PPS

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	40,124	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
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0		44.00
45.00	04500	NURSING FACILITY	0	0	0	0		45.00
200.00		Total (lines 30 through 199)	0	0	0	40,124	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	67,622	0.00	3,760	30.00
31.00	03100	INTENSIVE CARE UNIT		40,124	7,381	5.44	522	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	5,739	0.00	708	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	8,099	0.00	96	41.00
42.00	04200	SUBPROVIDER	0	0	0	0.00	0	42.00
43.00	04300	NURSERY		0	6,959	0.00	465	43.00
44.00	04400	SKILLED NURSING FACILITY		0	0	0.00	0	44.00
45.00	04500	NURSING FACILITY		0	0	0.00	0	45.00
200.00		Total (lines 30 through 199)		40,124	95,800		5,551	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	2,840	31.00
40.00	04000	SUBPROVIDER - IPF	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	41.00
42.00	04200	SUBPROVIDER	0	42.00
43.00	04300	NURSERY	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	44.00
45.00	04500	NURSING FACILITY	0	45.00
200.00		Total (lines 30 through 199)	2,840	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part IV Date/Time Prepared: 2/25/2019 3:00 pm

Title XIX | 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	41,888	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
65.01	06501	SLEEP LAB	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	42,770	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	0	0	1,020,080	91.00
91.01	09101	OP MENTAL HEALTH	0	0	0	0	0	91.01
91.02	09102	DIABETES CENTER	0	0	0	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
200.00		Total (lines 50 through 199)	0	0	0	0	1,104,738	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part IV Date/Time Prepared: 2/25/2019 3:00 pm

Title XIX | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	141,390,207	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	29,871,140	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	41,888	41,888	8,903,861	0.004704	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	175,885,909	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	31,130,469	0.000000	54.01
57.00	05700	CT SCAN	0	0	0	122,972,191	0.000000	57.00
58.00	05800	MRI	0	0	0	31,033,566	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	182,948,493	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	8,716,748	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	13,179,801	0.000000	65.00
65.01	06501	SLEEP LAB	0	0	0	3,525,988	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	11,394,756	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	9,594,825	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	42,770	42,770	23,914,734	0.001788	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	2,653,239	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	90,016,323	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	45,887,852	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	71,239,142	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	4,180,341	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000	89.00
90.00	09000	CLINIC	0	0	0	1,129,568	0.000000	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	0.000000	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	0.000000	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0	0	0.000000	90.03
91.00	09100	EMERGENCY	0	1,020,080	1,020,080	103,082,178	0.009896	91.00
91.01	09101	OP MENTAL HEALTH	0	0	0	1,683,199	0.000000	91.01
91.02	09102	DIABETES CENTER	0	0	0	383,751	0.000000	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	13,618,209	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0.000000	94.00
200.00		Total (lines 50 through 199)	0	1,104,738	1,104,738	1,128,336,490		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part IV Date/Time Prepared: 2/25/2019 3:00 pm

Title XIX | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.004704	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	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	54.01
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
65.01	06501	SLEEP LAB	0.000000	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.001788	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	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	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	89.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	HOMER GLEN LAB	0.000000	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0.000000	0	0	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0.000000	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.009896	0	0	0	0	91.00
91.01	09101	OP MENTAL HEALTH	0.000000	0	0	0	0	91.01
91.02	09102	DIABETES CENTER	0.000000	0	0	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0.000000	0	0	0	0	94.00
200.00		Total (lines 50 through 199)		0	0	0	0	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0213 | Component CCN: 14-S213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part II | Date/Time Prepared: 2/25/2019 3:00 pm

Title XIX | Subprovider - IPF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,445,434	141,390,207	0.045586	0	0	50.00
51.00	05100	RECOVERY ROOM	346,083	29,871,140	0.011586	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	662,597	8,903,861	0.074417	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,858,600	175,885,909	0.027624	0	0	54.00
54.01	05401	ULTRASOUND	468,295	31,130,469	0.015043	0	0	54.01
57.00	05700	CT SCAN	804,070	122,972,191	0.006539	0	0	57.00
58.00	05800	MRI	585,509	31,033,566	0.018867	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	899,130	182,948,493	0.004915	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	120,905	8,716,748	0.013870	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	307,013	13,179,801	0.023294	0	0	65.00
65.01	06501	SLEEP LAB	62,296	3,525,988	0.017668	0	0	65.01
66.00	06600	PHYSICAL THERAPY	172,668	11,394,756	0.015153	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	158,572	9,594,825	0.016527	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	269,009	23,914,734	0.011249	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	76,667	2,653,239	0.028896	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,313,028	90,016,323	0.014587	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,098,247	45,887,852	0.023933	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,330,325	71,239,142	0.018674	0	0	73.00
74.00	07400	RENAL DIALYSIS	217,262	4,180,341	0.051972	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	54,285	1,129,568	0.048058	0	0	90.00
90.01	09001	HOMER GLEN LAB	0	0	0.000000	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0.000000	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0.000000	0	0	90.03
91.00	09100	EMERGENCY	2,778,406	103,082,178	0.026953	0	0	91.00
91.01	09101	OP MENTAL HEALTH	178,002	1,683,199	0.105752	0	0	91.01
91.02	09102	DIABETES CENTER	18,427	383,751	0.048018	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	13,618,209	0.000000	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0.000000	0	0	94.00
200.00		Total (lines 50 through 199)	23,224,830	1,128,336,490		0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0213 | Component CCN: 14-S213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part IV Date/Time Prepared: 2/25/2019 3:00 pm

Title XIX | Subprovider - IPF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	41,888	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
65.01	06501	SLEEP LAB	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	42,770	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	0	0	1,020,080	91.00
91.01	09101	OP MENTAL HEALTH	0	0	0	0	0	91.01
91.02	09102	DIABETES CENTER	0	0	0	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
200.00		Total (lines 50 through 199)	0	0	0	0	1,104,738	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0213 | Component CCN: 14-S213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part IV | Date/Time Prepared: 2/25/2019 3:00 pm

Title XIX | Subprovider - IPF | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	141,390,207	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	29,871,140	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	41,888	41,888	8,903,861	0.004704	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	175,885,909	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	31,130,469	0.000000	54.01
57.00	05700	CT SCAN	0	0	0	122,972,191	0.000000	57.00
58.00	05800	MRI	0	0	0	31,033,566	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	182,948,493	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	8,716,748	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	13,179,801	0.000000	65.00
65.01	06501	SLEEP LAB	0	0	0	3,525,988	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	11,394,756	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	9,594,825	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	42,770	42,770	23,914,734	0.001788	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	2,653,239	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	90,016,323	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	45,887,852	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	71,239,142	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	4,180,341	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000	89.00
90.00	09000	CLINIC	0	0	0	1,129,568	0.000000	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	0.000000	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	0.000000	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0	0	0.000000	90.03
91.00	09100	EMERGENCY	0	1,020,080	1,020,080	103,082,178	0.009896	91.00
91.01	09101	OP MENTAL HEALTH	0	0	0	1,683,199	0.000000	91.01
91.02	09102	DIABETES CENTER	0	0	0	383,751	0.000000	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	13,618,209	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0.000000	94.00
200.00		Total (lines 50 through 199)	0	1,104,738	1,104,738	1,128,336,490		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0213 | Component CCN: 14-S213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part IV | Date/Time Prepared: 2/25/2019 3:00 pm

Title XIX | Subprovider - IPF | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.004704	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	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	54.01
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
65.01	06501	SLEEP LAB	0.000000	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.001788	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	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	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	89.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	HOMER GLEN LAB	0.000000	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0.000000	0	0	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0.000000	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.009896	0	0	0	0	91.00
91.01	09101	OP MENTAL HEALTH	0.000000	0	0	0	0	91.01
91.02	09102	DIABETES CENTER	0.000000	0	0	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0.000000	0	0	0	0	94.00
200.00		Total (lines 50 through 199)		0	0	0	0	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0213 | Component CCN: 14-T213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part II Date/Time Prepared: 2/25/2019 3:00 pm

Title XIX | Subprovider - IRF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,445,434	141,390,207	0.045586	0	0	50.00
51.00	05100	RECOVERY ROOM	346,083	29,871,140	0.011586	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	662,597	8,903,861	0.074417	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,858,600	175,885,909	0.027624	0	0	54.00
54.01	05401	ULTRASOUND	468,295	31,130,469	0.015043	0	0	54.01
57.00	05700	CT SCAN	804,070	122,972,191	0.006539	0	0	57.00
58.00	05800	MRI	585,509	31,033,566	0.018867	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	899,130	182,948,493	0.004915	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	120,905	8,716,748	0.013870	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	307,013	13,179,801	0.023294	0	0	65.00
65.01	06501	SLEEP LAB	62,296	3,525,988	0.017668	0	0	65.01
66.00	06600	PHYSICAL THERAPY	172,668	11,394,756	0.015153	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	158,572	9,594,825	0.016527	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	269,009	23,914,734	0.011249	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	76,667	2,653,239	0.028896	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,313,028	90,016,323	0.014587	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,098,247	45,887,852	0.023933	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,330,325	71,239,142	0.018674	0	0	73.00
74.00	07400	RENAL DIALYSIS	217,262	4,180,341	0.051972	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	54,285	1,129,568	0.048058	0	0	90.00
90.01	09001	HOMER GLEN LAB	0	0	0.000000	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0.000000	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0.000000	0	0	90.03
91.00	09100	EMERGENCY	2,778,406	103,082,178	0.026953	0	0	91.00
91.01	09101	OP MENTAL HEALTH	178,002	1,683,199	0.105752	0	0	91.01
91.02	09102	DIABETES CENTER	18,427	383,751	0.048018	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	13,618,209	0.000000	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0.000000	0	0	94.00
200.00		Total (lines 50 through 199)	23,224,830	1,128,336,490		0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0213 | Component CCN: 14-T213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part IV Date/Time Prepared: 2/25/2019 3:00 pm

Title XIX | Subprovider - IRF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	41,888	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
65.01	06501	SLEEP LAB	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	42,770	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	0	0	1,020,080	91.00
91.01	09101	OP MENTAL HEALTH	0	0	0	0	0	91.01
91.02	09102	DIABETES CENTER	0	0	0	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0		0		0	92.00
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
200.00		Total (lines 50 through 199)	0	0	0	0	1,104,738	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0213 | Component CCN: 14-T213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part IV | Date/Time Prepared: 2/25/2019 3:00 pm

Title XIX | Subprovider - IRF | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of cols. 1, 2, 3, and 4)	Total Outpatient Cost (sum of cols. 2, 3, and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	141,390,207	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	29,871,140	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	41,888	41,888	8,903,861	0.004704	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	175,885,909	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	31,130,469	0.000000	54.01
57.00	05700	CT SCAN	0	0	0	122,972,191	0.000000	57.00
58.00	05800	MRI	0	0	0	31,033,566	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	182,948,493	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	8,716,748	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	13,179,801	0.000000	65.00
65.01	06501	SLEEP LAB	0	0	0	3,525,988	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	11,394,756	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	9,594,825	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	42,770	42,770	23,914,734	0.001788	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	2,653,239	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	90,016,323	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	45,887,852	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	71,239,142	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	4,180,341	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000	89.00
90.00	09000	CLINIC	0	0	0	1,129,568	0.000000	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	0.000000	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	0.000000	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0	0	0.000000	90.03
91.00	09100	EMERGENCY	0	1,020,080	1,020,080	103,082,178	0.009896	91.00
91.01	09101	OP MENTAL HEALTH	0	0	0	1,683,199	0.000000	91.01
91.02	09102	DIABETES CENTER	0	0	0	383,751	0.000000	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	13,618,209	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0.000000	94.00
200.00		Total (lines 50 through 199)	0	1,104,738	1,104,738	1,128,336,490		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0213 | Component CCN: 14-T213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D Part IV Date/Time Prepared: 2/25/2019 3:00 pm

Title XIX | Subprovider - IRF | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.004704	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	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	54.01
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000000	0	0	0	0	65.00
65.01	06501	SLEEP LAB	0.000000	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.001788	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	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	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	89.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	HOMER GLEN LAB	0.000000	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0.000000	0	0	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0.000000	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.009896	0	0	0	0	91.00
91.01	09101	OP MENTAL HEALTH	0.000000	0	0	0	0	91.01
91.02	09102	DIABETES CENTER	0.000000	0	0	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0.000000	0	0	0	0	94.00
200.00		Total (lines 50 through 199)		0	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D-1 | Date/Time Prepared: 2/25/2019 3:00 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)	67,622	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	67,622	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)	55,864	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	25,441	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)	68,387,365	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)	68,387,365	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)	68,387,365	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)	1,011.32	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	25,728,992	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)	25,728,992	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D-1 | Date/Time Prepared: 2/25/2019 3:00 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	15,351,413	7,381	2,079.86	3,266	6,792,823	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)	38,269,843	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	70,791,658	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)	4,272,598	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	3,708,633	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	7,981,231	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	62,810,427	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)	11,758	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,011.32	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	11,891,101	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D-1 | Date/Time Prepared: 2/25/2019 3:00 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	9,115,584	68,387,365	0.133293	11,891,101	1,585,001	90.00
91.00	Nursing School cost	0	68,387,365	0.000000	11,891,101	0	91.00
92.00	Allied health cost	0	68,387,365	0.000000	11,891,101	0	92.00
93.00	All other Medical Education	0	68,387,365	0.000000	11,891,101	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-0213 Component CCN: 14-S213	Period: From 10/01/2017 To 09/30/2018	Worksheet D-1 Date/Time Prepared: 2/25/2019 3:00 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)	5,739	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,739	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)	5,739	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)	989	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	5,215,904	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5,215,904	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	5,215,904	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)	908.85	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	898,853	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)	898,853	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0213 | Component CCN: 14-S213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D-1 | Date/Time Prepared: 2/25/2019 3:00 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)	76,371	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	975,224	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)	133,347	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	9,410	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	142,757	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	832,467	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: 14-0213 Component CCN: 14-S213	Period: From 10/01/2017 To 09/30/2018	Worksheet D-1 Date/Time Prepared: 2/25/2019 3:00 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	773,780	5,215,904	0.148350	0	0	90.00
91.00	Nursing School cost	0	5,215,904	0.000000	0	0	91.00
92.00	Allied health cost	0	5,215,904	0.000000	0	0	92.00
93.00	All other Medical Education	0	5,215,904	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-0213 Component CCN: 14-T213	Period: From 10/01/2017 To 09/30/2018	Worksheet D-1 Date/Time Prepared: 2/25/2019 3:00 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)	8,099	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	8,099	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	8,099	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)	5,757	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	10,255,809	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	10,255,809	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	10,255,809	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)	1,266.31	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	7,290,147	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	7,290,147	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0213 | Component CCN: 14-T213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D-1 | Date/Time Prepared: 2/25/2019 3:00 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)	1,332,942	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	8,623,089	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)	1,058,367	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	89,418	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	1,147,785	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	7,475,304	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: 14-0213 Component CCN: 14-T213	Period: From 10/01/2017 To 09/30/2018	Worksheet D-1 Date/Time Prepared: 2/25/2019 3:00 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	1,488,914	10,255,809	0.145178	0	0	90.00
91.00	Nursing School cost	0	10,255,809	0.000000	0	0	91.00
92.00	Allied health cost	0	10,255,809	0.000000	0	0	92.00
93.00	All other Medical Education	0	10,255,809	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D-1 | Date/Time Prepared: 2/25/2019 3:00 pm

Title XIX | 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)	67,622	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	67,622	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)	55,864	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)	3,760	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)	6,959	15.00
16.00	Nursery days (title V or XIX only)	465	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)	68,387,365	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)	68,387,365	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)	68,387,365	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)	1,011.32	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	3,802,563	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	3,802,563	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D-1 | Date/Time Prepared: 2/25/2019 3:00 pm

Title XIX | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	9,501,657	6,959	1,365.38	465	634,902	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	15,351,413	7,381	2,079.86	522	1,085,687	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	5,523,152	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)	813,221	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	813,221	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	4,709,931	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)	11,758	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	1,011.32	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	11,891,101	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D-1 | Date/Time Prepared: 2/25/2019 3:00 pm

Title XIX | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	9,115,584	68,387,365	0.133293	11,891,101	1,585,001	90.00
91.00	Nursing School cost	0	68,387,365	0.000000	11,891,101	0	91.00
92.00	Allied health cost	0	68,387,365	0.000000	11,891,101	0	92.00
93.00	All other Medical Education	0	68,387,365	0.000000	11,891,101	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-0213 Component CCN: 14-S213	Period: From 10/01/2017 To 09/30/2018	Worksheet D-1 Date/Time Prepared: 2/25/2019 3:00 pm
	Title XIX	Subprovider - IPF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	5,739	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	5,739	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)	5,739	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)	708	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)	6,959	15.00
16.00	Nursery days (title V or XIX only)	465	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	5,215,904	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5,215,904	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	5,215,904	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)	908.85	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	643,466	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)	643,466	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0213 | Component CCN: 14-S213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D-1 | Date/Time Prepared: 2/25/2019 3:00 pm

Title XIX | Subprovider - IPF | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	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)	0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	643,466	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)	95,460	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	95,460	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	548,006	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: 14-0213 Component CCN: 14-S213	Period: From 10/01/2017 To 09/30/2018	Worksheet D-1 Date/Time Prepared: 2/25/2019 3:00 pm
	Title XIX	Subprovider - IPF	PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	773,780	5,215,904	0.148350	0	0	90.00
91.00	Nursing School cost	0	5,215,904	0.000000	0	0	91.00
92.00	Allied health cost	0	5,215,904	0.000000	0	0	92.00
93.00	All other Medical Education	0	5,215,904	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-0213 Component CCN: 14-T213	Period: From 10/01/2017 To 09/30/2018	Worksheet D-1 Date/Time Prepared: 2/25/2019 3:00 pm
	Title XIX	Subprovider - IRF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	8,099	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	8,099	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	8,099	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)	96	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)	6,959	15.00
16.00	Nursery days (title V or XIX only)	465	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	10,255,809	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	10,255,809	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	10,255,809	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)	1,266.31	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	121,566	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)	121,566	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0213 | Component CCN: 14-T213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D-1 | Date/Time Prepared: 2/25/2019 3:00 pm

Title XIX | Subprovider - IRF | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	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)	0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	121,566	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)	17,649	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	17,649	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	103,917	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: 14-0213 | Component CCN: 14-T213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D-1 | Date/Time Prepared: 2/25/2019 3:00 pm

Title XIX | Subprovider - IRF | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,488,914	10,255,809	0.145178	0	0	90.00
91.00	Nursing School cost	0	10,255,809	0.000000	0	0	91.00
92.00	Allied health cost	0	10,255,809	0.000000	0	0	92.00
93.00	All other Medical Education	0	10,255,809	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-0213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D-3 | Date/Time Prepared: 2/25/2019 3:00 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		31,043,631		30.00
31.00	03100	INTENSIVE CARE UNIT		9,134,613		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.283825	19,763,850	5,609,475	50.00
51.00	05100	RECOVERY ROOM	0.095096	4,029,994	383,236	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.824206	13,379	11,027	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.163801	16,960,073	2,778,077	54.00
54.01	05401	ULTRASOUND	0.095773	4,287,084	410,587	54.01
57.00	05700	CT SCAN	0.034848	17,464,365	608,598	57.00
58.00	05800	MRI	0.083769	3,898,266	326,554	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.088186	28,680,768	2,529,242	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.304803	2,312,177	704,758	63.00
65.00	06500	RESPIRATORY THERAPY	0.279736	6,315,918	1,766,790	65.00
65.01	06501	SLEEP LAB	0.190377	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.293609	2,931,724	860,781	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.358491	522	187	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.116189	6,501,363	755,387	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.194271	292,818	56,886	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.224529	16,738,955	3,758,381	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.592906	12,762,082	7,566,715	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.348202	16,596,363	5,778,887	73.00
74.00	07400	RENAL DIALYSIS	0.297493	2,240,449	666,518	74.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000	CLINIC	1.045685	362	379	90.00
90.01	09001	HOMER GLEN LAB	0.000000	0	0	90.01
90.02	09002	HOMER GLEN FEC	0.000000	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0.000000	0	0	90.03
91.00	09100	EMERGENCY	0.212259	13,358,226	2,835,404	91.00
91.01	09101	OP MENTAL HEALTH	0.647587	0	0	91.01
91.02	09102	DIABETES CENTER	1.044631	19,106	19,959	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.873177	964,312	842,015	92.00
		OTHER REIMBURSABLE COST CENTERS				
94.00	09400	HOME PROGRAM DIALYSIS	0.000000	0	0	94.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		176,132,156	38,269,843	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)		176,132,156		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-0213 | Component CCN: 14-S213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D-3 | Date/Time Prepared: 2/25/2019 3:00 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		1,114,660		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.283825	31	9	50.00
51.00	05100	RECOVERY ROOM	0.095096	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.824206	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.163801	7,703	1,262	54.00
54.01	05401	ULTRASOUND	0.095773	6,406	614	54.01
57.00	05700	CT SCAN	0.034848	19,826	691	57.00
58.00	05800	MRI	0.083769	5,882	493	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.088186	209,033	18,434	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.304803	4,434	1,351	63.00
65.00	06500	RESPIRATORY THERAPY	0.279736	15,232	4,261	65.00
65.01	06501	SLEEP LAB	0.190377	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.293609	3,888	1,142	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.358491	1	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.116189	6,744	784	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.194271	833	162	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.224529	6,610	1,484	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.592906	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.348202	18,740	6,525	73.00
74.00	07400	RENAL DIALYSIS	0.297493	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000	CLINIC	1.045685	0	0	90.00
90.01	09001	HOMER GLEN LAB	0.000000	0	0	90.01
90.02	09002	HOMER GLEN FEC	0.000000	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0.000000	0	0	90.03
91.00	09100	EMERGENCY	0.212259	184,488	39,159	91.00
91.01	09101	OP MENTAL HEALTH	0.647587	0	0	91.01
91.02	09102	DIABETES CENTER	1.044631	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.873177	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
94.00	09400	HOME PROGRAM DIALYSIS	0.000000	0	0	94.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		489,851	76,371	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)		489,851		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-0213 | Component CCN: 14-T213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet D-3 | Date/Time Prepared: 2/25/2019 3:00 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		9,443,930		41.00
42.00	04200	SUBPROVIDER		0		42.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.283825	1,849	525	50.00
51.00	05100	RECOVERY ROOM	0.095096	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.824206	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.163801	147,903	24,227	54.00
54.01	05401	ULTRASOUND	0.095773	95,729	9,168	54.01
57.00	05700	CT SCAN	0.034848	250,808	8,740	57.00
58.00	05800	MRI	0.083769	76,090	6,374	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.088186	1,405,773	123,969	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.304803	45,959	14,008	63.00
65.00	06500	RESPIRATORY THERAPY	0.279736	299,606	83,811	65.00
65.01	06501	SLEEP LAB	0.190377	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.293609	2,395,749	703,413	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.358491	307	110	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.116189	60,195	6,994	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.194271	4,583	890	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.224529	377,798	84,827	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.592906	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.348202	538,973	187,671	73.00
74.00	07400	RENAL DIALYSIS	0.297493	255,821	76,105	74.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000	CLINIC	1.045685	0	0	90.00
90.01	09001	HOMER GLEN LAB	0.000000	0	0	90.01
90.02	09002	HOMER GLEN FEC	0.000000	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0.000000	0	0	90.03
91.00	09100	EMERGENCY	0.212259	476	101	91.00
91.01	09101	OP MENTAL HEALTH	0.647587	0	0	91.01
91.02	09102	DIABETES CENTER	1.044631	1,923	2,009	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.873177	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
94.00	09400	HOME PROGRAM DIALYSIS	0.000000	0	0	94.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		5,959,542	1,332,942	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00		Net charges (line 200 minus line 201)		5,959,542		202.00

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		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	60,414,538	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)	373,947	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	15,661,920	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	224.79	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)	0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)	0.00	7.00
7.01	ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	1.98	30.00
31.00	Percentage of Medicaid patient days (see instructions)	13.77	31.00
32.00	Sum of lines 30 and 31	15.75	32.00
33.00	Allowable disproportionate share percentage (see instructions)	2.99	33.00
34.00	Disproportionate share adjustment (see instructions)	451,599	34.00

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		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	0	0	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000000000	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	0	2,198,277	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	0	2,198,277	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	2,198,277		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)	63,438,361		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)	63,438,361	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)	5,124,381	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)	0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).	0	52.00
53.00	Nursing and Allied Health Managed Care payment	85,624	53.00
54.00	Special add-on payments for new technologies	0	54.00
54.01	Islet isolation add-on payment	0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)	0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)	0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).	17,767	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)	143,880	58.00
59.00	Total (sum of amounts on lines 49 through 58)	68,810,013	59.00
60.00	Primary payer payments	55,519	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	68,754,494	61.00
62.00	Deductibles billed to program beneficiaries	6,772,816	62.00
63.00	Coinsurance billed to program beneficiaries	212,860	63.00
64.00	Allowable bad debts (see instructions)	952,252	64.00
65.00	Adjusted reimbursable bad debts (see instructions)	618,964	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	418,510	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	62,387,782	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)	335,293	70.93
70.94	HRR adjustment amount (see instructions)	-622,269	70.94
70.95	Recovery of accelerated depreciation	0	70.95

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		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)		62,100,806	71.00
71.01	Sequestration adjustment (see instructions)		1,242,016	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		60,898,892	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)		-40,102	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		1,713,969	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

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

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 14-0213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 2/25/2019 3:00 pm

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	0	0		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	60,414,538	0		60,414,538	60,414,538	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	373,947	0	0	373,947	373,947	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	15,661,920	0	0	0	0	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0299	0.0299	0.0299	0.0299		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	451,599	0	0	451,599	451,599	11.00
11.01	Uncompensated care payments	36.00	2,198,277	0	0	2,198,277	2,198,277	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	63,438,361	0	0	63,438,361	63,438,361	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	63,438,361	0	0	63,438,361	63,438,361	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	5,124,381	0	0	5,124,381	5,124,381	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17.00
17.01	Net organ aquisition cost							17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02

LOW VOLUME CALCULATION EXHIBIT 4

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	0	68,562,742	68,562,742	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	4,920,622	0	0	4,920,622	4,920,622	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	44,331	0	0	44,331	44,331	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0324	0.0324	0.0324	0.0324		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	159,428	0	0	159,428	159,428	25.00
26.00	Total prospective capital payments (see instructions)	12.00	5,124,381	0	0	5,124,381	5,124,381	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 14-0213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 2/25/2019 3:00 pm

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		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	0		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	60,414,538		60,414,538	60,414,538	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	373,947	0	373,947	373,947	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	15,661,920	0	0	0	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0299	0.0299	0.0299		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	451,599	0	451,599	451,599	11.00
11.01	Uncompensated care payments	36.00	2,198,277	0	2,198,277	2,198,277	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	63,438,361	0	63,438,361	63,438,361	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	63,438,361	0	63,438,361	63,438,361	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	5,124,381	0	5,124,381	5,124,381	16.00
17.00	Special add-on payments for new technologies	54.00	0	0	0	0	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			0	68,562,742	68,562,742	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 14-0213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 2/25/2019 3:00 pm

Title XVIII | Hospital | PPS

		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	4,920,622	0	4,920,622	4,920,622	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	44,331	0	44,331	44,331	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0324	0.0324	0.0324		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	159,428	0	159,428	159,428	25.00
26.00	Total prospective capital payments (see instructions)	12.00	5,124,381	0	5,124,381	5,124,381	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	335,293	0	335,293	335,293	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-622,269	0	-622,269	-622,269	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0213	Period: From 10/01/2017 To 09/30/2018	Worksheet E Part B Date/Time Prepared: 2/25/2019 3:00 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	40,687	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	29,265,379	2.00
3.00	OPPS payments	31,906,042	3.00
4.00	Outlier payment (see instructions)	67,729	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	120,206	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	40,687	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	140,521	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)	140,521	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)	140,521	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	99,834	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)	40,687	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)	32,093,977	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)	8,657	25.00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions)	5,898,488	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)	26,227,519	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)	26,227,519	30.00
31.00	Primary payer payments	5,568	31.00
32.00	Subtotal (line 30 minus line 31)	26,221,951	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)	644,651	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	419,023	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	402,511	36.00
37.00	Subtotal (see instructions)	26,640,974	37.00
38.00	MSP-LCC reconciliation amount from PS&R	-182	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)	26,641,156	40.00
40.01	Sequestration adjustment (see instructions)	532,823	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	25,888,500	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	219,833	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	563,684	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet E-1 Part I Date/Time Prepared: 2/25/2019 3:00 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		60,898,892		25,870,898	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	04/05/2018	17,602	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		17,602	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)		60,898,892		25,888,500	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		219,833	6.01
6.02	SETTLEMENT TO PROGRAM		40,102		0	6.02
7.00	Total Medicare program liability (see instructions)		60,858,790		26,108,333	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0213 | Component CCN: 14-S213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet E-1 Part I | Date/Time Prepared: 2/25/2019 3:00 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		770,357		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)		770,357		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		50,170		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		820,527		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: 14-0213 | Component CCN: 14-T213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet E-1 Part I | Date/Time Prepared: 2/25/2019 3:00 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		9,045,416		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)		9,045,416		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		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		8,057		0	6.02
7.00	Total Medicare program liability (see instructions)		9,037,359		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 14-0213	Period: From 10/01/2017 To 09/30/2018	Worksheet E-1 Part II Date/Time Prepared: 2/25/2019 3:00 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: 14-0213 Component CCN: 14-S213	Period: From 10/01/2017 To 09/30/2018	Worksheet E-3 Part II Date/Time Prepared: 2/25/2019 3:00 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)	899,983	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)	15.723288	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)	899,983	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)	899,983	16.00
17.00	Primary payer payments	0	17.00
18.00	Subtotal (line 16 less line 17).	899,983	18.00
19.00	Deductibles	107,916	19.00
20.00	Subtotal (line 18 minus line 19)	792,067	20.00
21.00	Coinsurance	5,982	21.00
22.00	Subtotal (line 20 minus line 21)	786,085	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	75,922	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	49,349	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	45,499	25.00
26.00	Subtotal (sum of lines 22 and 24)	835,434	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)	1,838	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)	837,272	31.00
31.01	Sequestration adjustment (see instructions)	16,745	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	31.02
32.00	Interim payments	770,357	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)	50,170	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	4,436	35.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	0	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0213 Component CCN: 14-T213	Period: From 10/01/2017 To 09/30/2018	Worksheet E-3 Part III Date/Time Prepared: 2/25/2019 3:00 pm
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	8,986,098	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0051	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	63,801	3.00
4.00	Outlier Payments	236,288	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)	22.189041	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)	9,286,187	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)	9,286,187	17.00
18.00	Primary payer payments	0	18.00
19.00	Subtotal (line 17 less line 18).	9,286,187	19.00
20.00	Deductibles	14,644	20.00
21.00	Subtotal (line 19 minus line 20)	9,271,543	21.00
22.00	Coinsurance	52,271	22.00
23.00	Subtotal (line 21 minus line 22)	9,219,272	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	3,708	24.00
25.00	Adjusted reimbursable bad debts (see instructions)	2,410	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)	9,221,682	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)	113	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)	9,221,795	32.00
32.01	Sequestration adjustment (see instructions)	184,436	32.01
32.02	Demonstration payment adjustment amount after sequestration	0	32.02
33.00	Interim payments	9,045,416	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)	-8,057	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	36.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	236,288	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

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

Provider CCN: 14-0213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet G | Date/Time Prepared: 2/25/2019 3:00 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	20,904,000	0	0	0	1.00
2.00	Temporary investments	2,217,000	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	38,905,000	0	0	0	4.00
5.00	Other receivable	1,327,000	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	6,339,000	0	0	0	8.00
9.00	Other current assets	24,775,000	0	0	0	9.00
10.00	Due from other funds	39,477,000	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	133,944,000	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	642,179,729	0	0	0	15.00
16.00	Accumulated depreciation	-243,624,729	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	398,555,000	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	206,540,000	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	35,745,000	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	242,285,000	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	774,784,000	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	24,935,000	0	0	0	37.00
38.00	Salaries, wages, and fees payable	15,899,000	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	7,505,000	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	0	0	0	0	43.00
44.00	Other current liabilities	43,090,000	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	91,429,000	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	383,333,000	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	5,305,000	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	388,638,000	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	480,067,000	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	294,717,000				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	294,717,000	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	774,784,000	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-0213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet G-1 | Date/Time Prepared: 2/25/2019 3:00 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		267,649,000		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		26,457,000				2.00
3.00	Total (sum of line 1 and line 2)		294,106,000		0		3.00
4.00	INCREASE IN TEMPORARILY RESTRICTED A	0		0		0	4.00
5.00	PERMANENTLY RESTRICED ASSETS	207,000		0		0	5.00
6.00	INCREASE UNRESTRICTED ASSETS	79,000		0		0	6.00
7.00	NETS ASSETS RELEASED FR. RESTRICTION	325,000		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)		611,000		0		10.00
11.00	Subtotal (line 3 plus line 10)		294,717,000		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		294,717,000		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 14-0213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet G-2 Parts I & II Date/Time Prepared: 2/25/2019 3:00 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	62,747,189		62,747,189	1.00
2.00	SUBPROVIDER - IPF	6,449,603		6,449,603	2.00
3.00	SUBPROVIDER - IRF	16,767,847		16,767,847	3.00
4.00	SUBPROVIDER	0		0	4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	0		0	7.00
8.00	NURSING FACILITY	0		0	8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	85,964,639		85,964,639	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	19,753,519		19,753,519	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)	19,753,519		19,753,519	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	105,718,158		105,718,158	17.00
18.00	Ancillary services	404,550,916	603,888,669	1,008,439,585	18.00
19.00	Outpatient services	31,724,132	88,172,772	119,896,904	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		5,622,727	5,622,727	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC		0	0	24.00
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	NURSERY	9,411,792	0	9,411,792	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	551,404,998	697,684,168	1,249,089,166	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		370,457,674		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)		370,457,674		43.00

STATEMENT OF REVENUES AND EXPENSES | Provider CCN: 14-0213 | Period: From 10/01/2017 To 09/30/2018 | Worksheet G-3 | Date/Time Prepared: 2/25/2019 3:00 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	1,249,089,166	1.00
2.00	Less contractual allowances and discounts on patients' accounts	830,594,125	2.00
3.00	Net patient revenues (line 1 minus line 2)	418,495,041	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	370,457,674	4.00
5.00	Net income from service to patients (line 3 minus line 4)	48,037,367	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISC - OTHER REVENUE	7,757,000	24.00
24.01	NON-OPERATING INCOME	9,947,000	24.01
24.02	ROUNDING	174	24.02
25.00	Total other income (sum of lines 6-24)	17,704,174	25.00
26.00	Total (line 5 plus line 25)	65,741,541	26.00
27.00	BAD DEBTS	15,854,860	27.00
27.01	JOINT VENTURE RECLASS	20,071,610	27.01
27.02	REVENUE RECLASS	3,358,071	27.02
28.00	Total other expenses (sum of line 27 and subscripts)	39,284,541	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	26,457,000	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 14-0213 | HHA CCN: 14-7452 | Period: From 10/01/2017 To 09/30/2018 | Worksheet H | Date/Time Prepared: 2/25/2019 3:00 pm

Home Health Agency I | PPS

		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	573,226	0	0	49	56,797	630,072	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	65,893	0	81,457	147,350	6.00
7.00	Physical Therapy	0	0	430	970,575	0	971,005	7.00
8.00	Occupational Therapy	0	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	1,277,303	0	0	0	0	1,277,303	10.00
11.00	Home Health Aide	53,368	0	7,593	0	872	61,833	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	1,903,897	0	73,916	970,624	139,126	3,087,563	24.00

		Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
		7.00	8.00	9.00	10.00			
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0			1.00
2.00	Capital Related - Movable Equipment	0	0	0	0			2.00
3.00	Plant Operation & Maintenance	0	0	0	0			3.00
4.00	Transportation	0	0	0	0			4.00
5.00	Administrative and General	20,778	650,850	0	650,850			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	147,350	0	147,350			6.00
7.00	Physical Therapy	0	971,005	0	971,005			7.00
8.00	Occupational Therapy	0	0	0	0			8.00
9.00	Speech Pathology	0	0	0	0			9.00
10.00	Medical Social Services	0	1,277,303	0	1,277,303			10.00
11.00	Home Health Aide	0	61,833	0	61,833			11.00
12.00	Supplies (see instructions)	0	0	0	0			12.00
13.00	Drugs	0	0	0	0			13.00
14.00	DME	0	0	0	0			14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	0	0	0			22.00
23.00	All Others (specify)	0	0	0	0			23.00
23.50	Telemedicine	0	0	0	0			23.50
24.00	Total (sum of lines 1-23)	20,778	3,108,341	0	3,108,341			24.00

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

COST ALLOCATION - HHA GENERAL SERVICE COST | Provider CCN: 14-0213 | HHA CCN: 14-7452 | Period: From 10/01/2017 To 09/30/2018 | Worksheet H-1 Part I | Date/Time Prepared: 2/25/2019 3:00 pm

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		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs: Bldgs & Fixtures	Capital Related Costs: Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	650,850	0	0	0	0	650,850	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	147,350	0	0	0	0	147,350	6.00
7.00	Physical Therapy	971,005	0	0	0	0	971,005	7.00
8.00	Occupational Therapy	0	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	1,277,303	0	0	0	0	1,277,303	10.00
11.00	Home Health Aide	61,833	0	0	0	0	61,833	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0		0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	3,108,341	0	0	0	0	3,108,341	24.00

		Administrative & General	Total (cols. 4A + 5)	
		5.00	6.00	
	GENERAL SERVICE COST CENTERS			
1.00	Capital Related - Bldg. & Fixtures			1.00
2.00	Capital Related - Movable Equipment			2.00
3.00	Plant Operation & Maintenance			3.00
4.00	Transportation			4.00
5.00	Administrative and General	650,850		5.00
	HHA REIMBURSABLE SERVICES			
6.00	Skilled Nursing Care	39,025	186,375	6.00
7.00	Physical Therapy	257,164	1,228,169	7.00
8.00	Occupational Therapy	0	0	8.00
9.00	Speech Pathology	0	0	9.00
10.00	Medical Social Services	338,285	1,615,588	10.00
11.00	Home Health Aide	16,376	78,209	11.00
12.00	Supplies (see instructions)	0	0	12.00
13.00	Drugs	0	0	13.00
14.00	DME	0	0	14.00
	HHA NONREIMBURSABLE SERVICES			
15.00	Home Dialysis Aide Services	0	0	15.00
16.00	Respiratory Therapy	0	0	16.00
17.00	Private Duty Nursing	0	0	17.00
18.00	Clinic	0	0	18.00
19.00	Health Promotion Activities	0	0	19.00
20.00	Day Care Program	0	0	20.00
21.00	Home Delivered Meals Program	0	0	21.00
22.00	Homemaker Service	0	0	22.00
23.00	All Others (specify)	0	0	23.00
23.50	Telemedicine	0	0	23.50
24.00	Total (sum of lines 1-23)		3,108,341	24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 14-0213 | HHA CCN: 14-7452 | Period: From 10/01/2017 To 09/30/2018 | Worksheet H-1 Part II | Date/Time Prepared: 2/25/2019 3:00 pm

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		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	0	0	0	0	-650,850	2,457,491	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	147,350	6.00
7.00	Physical Therapy	0	0	0	0	0	971,005	7.00
8.00	Occupational Therapy	0	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	1,277,303	10.00
11.00	Home Health Aide	0	0	0	0	0	61,833	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0		0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	0	0	0	0	-650,850	2,457,491	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		650,850	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.264843	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0213 HHA CCN: 14-7452

Period: From 10/01/2017 To 09/30/2018

Worksheet H-2 Part I Date/Time Prepared: 2/25/2019 3:00 pm

Home Health Agency I

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	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		0	1.00	2.00	4.00	4A	5.00	
1.00	Administrative and General	0	0	1,560	519,835	521,395	131,917	1.00
2.00	Skilled Nursing Care	186,375	0	0	0	186,375	47,154	2.00
3.00	Physical Therapy	1,228,169	0	0	0	1,228,169	310,737	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	1,615,588	0	0	0	1,615,588	408,756	6.00
7.00	Home Health Aide	78,209	0	0	0	78,209	19,788	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	3,108,341	0	1,560	519,835	3,629,736	918,352	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000		21.00

	Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION	
		7.00	8.00	9.00	10.00	11.00	13.00	
1.00	Administrative and General	0	0	0	0	0	185,131	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	0	0	0	0	185,131	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0213 | HHA CCN: 14-7452 | Period: From 10/01/2017 To 09/30/2018 | Worksheet H-2 Part I | Date/Time Prepared: 2/25/2019 3:00 pm

Home Health Agency I | PPS

	Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	PARAMED ED PRGM	Subtotal	
		14.00	15.00	16.00	17.00	23.00	24.00	
1.00	Administrative and General	10,309	0	0	0	0	848,752	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	233,529	2.00
3.00	Physical Therapy	0	0	0	0	0	1,538,906	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	2,024,344	6.00
7.00	Home Health Aide	0	0	0	0	0	97,997	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	10,309	0	0	0	0	4,743,528	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

	Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs			
		25.00	26.00	27.00	28.00			
1.00	Administrative and General	0	848,752					1.00
2.00	Skilled Nursing Care	0	233,529	50,891	284,420			2.00
3.00	Physical Therapy	0	1,538,906	335,360	1,874,266			3.00
4.00	Occupational Therapy	0	0	0	0			4.00
5.00	Speech Pathology	0	0	0	0			5.00
6.00	Medical Social Services	0	2,024,344	441,145	2,465,489			6.00
7.00	Home Health Aide	0	97,997	21,356	119,353			7.00
8.00	Supplies (see instructions)	0	0	0	0			8.00
9.00	Drugs	0	0	0	0			9.00
10.00	DME	0	0	0	0			10.00
11.00	Home Dialysis Aide Services	0	0	0	0			11.00
12.00	Respiratory Therapy	0	0	0	0			12.00
13.00	Private Duty Nursing	0	0	0	0			13.00
14.00	Clinic	0	0	0	0			14.00
15.00	Health Promotion Activities	0	0	0	0			15.00
16.00	Day Care Program	0	0	0	0			16.00
17.00	Home Delivered Meals Program	0	0	0	0			17.00
18.00	Homemaker Service	0	0	0	0			18.00
19.00	All Others (specify)	0	0	0	0			19.00
19.50	Telemedicine	0	0	0	0			19.50
20.00	Total (sum of lines 1-19) (2)	0	4,743,528	848,752	4,743,528			20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.			0.217921				21.00

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-0213 | HHA CCN: 14-7452 | Period: From 10/01/2017 To 09/30/2018 | Worksheet H-2 Part II | Date/Time Prepared: 2/25/2019 3:00 pm

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	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)	OPERATION OF PLANT (SQUARE FEET)	
		1.00	2.00	4.00	5A	5.00	7.00	
1.00	Administrative and General	0	1,193	1,903,898	0	521,395	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	186,375	0	2.00
3.00	Physical Therapy	0	0	0	0	1,228,169	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	1,615,588	0	6.00
7.00	Home Health Aide	0	0	0	0	78,209	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	1,193	1,903,898		3,629,736	0	20.00
21.00	Total cost to be allocated	0	1,560	519,835		918,352	0	21.00
22.00	Unit cost multiplier	0.000000	1.307628	0.273037		0.253008	0.000000	22.00

	Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRSING)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
		8.00	9.00	10.00	11.00	13.00	14.00	
1.00	Administrative and General	0	0	0	0	47,809	79,935	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	0	0	0	47,809	79,935	20.00
21.00	Total cost to be allocated	0	0	0	0	185,131	10,309	21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.000000	0.000000	3.872304	0.128967	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 14-0213
HHA CCN: 14-7452

Period: From 10/01/2017 To 09/30/2018

Worksheet H-2 Part II
Date/Time Prepared: 2/25/2019 3:00 pm

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

APPORTIONMENT OF PATIENT SERVICE COSTS | Provider CCN: 14-0213 | HHA CCN: 14-7452 | Period: From 10/01/2017 To 09/30/2018 | Worksheet H-3 Part I | Date/Time Prepared: 2/25/2019 3:00 pm

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	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	284,420		284,420	11,792	24.12	1.00
2.00	Physical Therapy	3.00	1,874,266	518,773	2,393,039	7,829	305.66	2.00
3.00	Occupational Therapy	4.00	0	238,390	238,390	2,934	81.25	3.00
4.00	Speech Pathology	5.00	0	0	0	384	0.00	4.00
5.00	Medical Social Services	6.00	2,465,489		2,465,489	140	17,610.64	5.00
6.00	Home Health Aide	7.00	119,353		119,353	1,350	88.41	6.00
7.00	Total (sum of lines 1-6)		4,743,528	757,163	5,500,691	24,429		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Program Visits: Part A	Program Visits: Part B Not Subject to Deductibles & Coinsurance	Program Visits: Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		16974	0	8,292			8.00
9.00	Physical Therapy		16974	0	5,361			9.00
10.00	Occupational Therapy		16974	0	2,141			10.00
11.00	Speech Pathology		16974	0	278			11.00
12.00	Medical Social Services		16974	0	110			12.00
13.00	Home Health Aide		16974	0	1,095			13.00
14.00	Total (sum of lines 8-13)			0	17,277			14.00

	Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	0	7,526	7,526	33,519	0.224529	15.00
16.00	Cost of Drugs	9.00	0	75	75	216	0.347222	16.00

	Cost Center Description	Program Visits: Part A	Program Visits: Part B Not Subject to Deductibles & Coinsurance	Program Visits: Part B Subject to Deductibles & Coinsurance	Cost of Services: Part A	Cost of Services: Part B Not Subject to Deductibles & Coinsurance	Cost of Services: Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	8,292		0	200,003		1.00
2.00	Physical Therapy	0	5,361		0	1,638,643		2.00
3.00	Occupational Therapy	0	2,141		0	173,956		3.00
4.00	Speech Pathology	0	278		0	0		4.00
5.00	Medical Social Services	0	110		0	1,937,170		5.00
6.00	Home Health Aide	0	1,095		0	96,809		6.00
7.00	Total (sum of lines 1-6)	0	17,277		0	4,046,581		7.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0213 HHA CCN: 14-7452 | Period: From 10/01/2017 To 09/30/2018 | Worksheet H-3 Part I Date/Time Prepared: 2/25/2019 3:00 pm

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	Cost Center Description							
		6.00	7.00	8.00	9.00	10.00	11.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8.00
9.00	Physical Therapy							9.00
10.00	Occupational Therapy							10.00
11.00	Speech Pathology							11.00
12.00	Medical Social Services							12.00
13.00	Home Health Aide							13.00
14.00	Total (sum of lines 8-13)							14.00

	Cost Center Description	Program Covered Charges			Cost of Services			
			Part B			Part B		
		Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	0	0	0	0	0	0	15.00
16.00	Cost of Drugs		0	0		0	0	16.00

	Cost Center Description	Total Program Cost (sum of cols. 9-10)						
		12.00						
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	200,003						1.00
2.00	Physical Therapy	1,638,643						2.00
3.00	Occupational Therapy	173,956						3.00
4.00	Speech Pathology	0						4.00
5.00	Medical Social Services	1,937,170						5.00
6.00	Home Health Aide	96,809						6.00
7.00	Total (sum of lines 1-6)	4,046,581						7.00

	Cost Center Description							
		12.00						
	Limitation Cost Computation							
8.00	Skilled Nursing Care							8.00
9.00	Physical Therapy							9.00
10.00	Occupational Therapy							10.00
11.00	Speech Pathology							11.00
12.00	Medical Social Services							12.00
13.00	Home Health Aide							13.00
14.00	Total (sum of lines 8-13)							14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0213 | HHA CCN: 14-7452 | Period: From 10/01/2017 To 09/30/2018 | Worksheet H-3 Part II | Date/Time Prepared: 2/25/2019 3:00 pm

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	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
		0	1.00	2.00	3.00	4.00		
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy	66.00	0.293609	1,766,885	518,773	col. 2, line 2.00		1.00
2.00	Occupational Therapy	67.00	0.358491	664,981	238,390	col. 2, line 3.00		2.00
3.00	Speech Pathology	68.00	0.000000	91,786	0	col. 2, line 4.00		3.00
4.00	Cost of Medical Supplies	71.00	0.224529	33,519	7,526	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.348202	216	75	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT | Provider CCN: 14-0213 | HHA CCN: 14-7452 | Period: From 10/01/2017 To 09/30/2018 | Worksheet H-4 Part I-II | Date/Time Prepared: 2/25/2019 3:00 pm

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		Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		1.00	2.00	3.00	
	PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
	Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0	1.00
2.00	Total charges	0	0	0	2.00
	Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0	3.00
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(b)	0	0	0	4.00
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000	5.00
6.00	Total customary charges (see instructions)	0	0	0	6.00
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	0	0	7.00
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0	8.00
9.00	Primary payer amounts	0	0	0	9.00

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	0	2,517,645	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	300,312	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	39,117	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	98,218	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	50,615	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	13,605	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	0	3,019,512	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	3,019,512	24.00
25.00	Coinsurance billed to program patients (from your records)		0	25.00
26.00	Net cost (line 24 minus line 25)	0	3,019,512	26.00
27.00	Reimbursable bad debts (from your records)			27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)	0	3,019,512	29.00
30.00	OTHER ADJUSTMENTS	0	1,604	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	30.50
30.99	Demonstration payment adjustment amount before sequestration	0	0	30.99
31.00	Subtotal (see instructions)	0	3,021,116	31.00
31.01	Sequestration adjustment (see instructions)	0	60,423	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	0	31.02
32.00	Interim payments (see instructions)	0	2,960,693	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)	0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	35.00

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

Provider CCN: 14-0213 | HHA CCN: 14-7452 | Period: From 10/01/2017 To 09/30/2018 | Worksheet H-5 | Date/Time Prepared: 2/25/2019 3:00 pm

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		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		2,960,693	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		2,960,693	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		2,960,693	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		0		1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 14-0213	Period: From 10/01/2017 To 09/30/2018	Worksheet L Parts I-III Date/Time Prepared: 2/25/2019 3:00 pm
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		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	4,920,622	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	44,331	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)	177.95	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	1.98	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	13.77	8.00
9.00	Sum of lines 7 and 8	15.75	9.00
10.00	Allowable disproportionate share percentage (see instructions)	3.24	10.00
11.00	Disproportionate share adjustment (see instructions)	159,428	11.00
12.00	Total prospective capital payments (see instructions)	5,124,381	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