

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g).

FORM APPROVED  
OMB NO. 0938-0050  
EXPIRES 05-31-2019

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-0008	Period: From 07/01/2016 To 06/30/2017	Worksheet S Parts I-III Date/Time Prepared: 11/30/2017 8:38 am
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<b>PART I - COST REPORT STATUS</b>			
Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report	Date: 11/30/2017 Time: 8:38 am	
	2. <input type="checkbox"/> Manually submitted cost report		
	3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. <input type="checkbox"/> Medicare Utilization. Enter "F" for Full or "L" for Low.		
Contractor use only	5. <input type="checkbox"/> 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. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> 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 OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by GOTTLIEB MEMORIAL HOSPITAL ( 14-0008 ) for the cost reporting period beginning 07/01/2016 and ending 06/30/2017 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.

(Signed) \_\_\_\_\_  
Officer or Administrator of Provider(s)

\_\_\_\_\_  
Title

\_\_\_\_\_  
Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00 Hospital	0	116,514	21,389	0	0	1.00
2.00 Subprovider - IPF	0	23,808	0		0	2.00
3.00 Subprovider - IRF	0	220,406	1		0	3.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
7.00 SKILLED NURSING FACILITY	0	26,850	-337		0	7.00
200.00 Total	0	387,578	21,053	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0008		Period: From 07/01/2016 To 06/30/2017		Worksheet S-2 Part I Date/Time Prepared: 11/30/2017 8:36 am				
1.00		2.00		3.00		4.00				
Hospital and Hospital Health Care Complex Address:										
1.00	Street: 8700 WEST NORTH AVENUE			PO Box:						1.00
2.00	City: MELROSE PARK			State: IL		Zip Code: 60160		County: COOK		2.00
		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
Hospital and Hospital-Based Component Identification:										
3.00	Hospital	GOTTLIEB MEMORIAL HOSPITAL	140008	16974	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF	GOTTLIEB MEMORIAL PSYCHIATRIC UNIT	14S008	16974	4	01/01/2007	N	P	N	4.00
5.00	Subprovider - IRF	GOTTLIEB MEMORIAL REHABILITATION UNI	14T008	16974	5	07/01/1999	N	P	O	5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF	GOTTLIEB SKILLED NURSING CARE	145526	16974		06/10/1985	N	P	N	9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA									12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
17.10	Hospital-Based (CORF) I									17.10
17.20	Hospital-Based (OPT) I									17.20
17.30	Hospital-Based (OOT) I									17.30
17.40	Hospital-Based (OSP) I									17.40
18.00	Renal Dialysis									18.00
19.00	Other									19.00
						From:		To:		
						1.00		2.00		
20.00	Cost Reporting Period (mm/dd/yyyy)					07/01/2016		06/30/2017		20.00
21.00	Type of Control (see instructions)					2				21.00
Inpatient PPS Information										
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y		N		22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					Y		Y		22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N		N		22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N		N		22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.							1 N		23.00
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid days	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.	456	1,120	2	3	2,796	50		24.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0008		Period: From 07/01/2016 To 06/30/2017		Worksheet S-2 Part I Date/Time Prepared: 11/30/2017 8:36 am			
		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.	762	66	0	0	0		25.00	
							Urban/Rural	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.					2	06/30/2017	27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00	
							Beginning:	Ending:	
							1.00	2.00	
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00	
37.01	Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see instructions)					N		37.01	
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00	
							Y/N	Y/N	
							1.00	2.00	
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N	40.00	
							V	XVIII	XIX
							1.00	2.00	3.00
Prospective Payment System (PPS)-Capital									
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	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 PPS capital? Enter "Y" for yes or "N" for no.					N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N	48.00
Teaching Hospitals									
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.					Y			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.					N			57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)					N			60.00
		Y/N	IME	Direct GME	IME	Direct GME			
		1.00	2.00	3.00	4.00	5.00			
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00		61.00	
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00				61.01	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0008

Period:  
From 07/01/2016  
To 06/30/2017

Worksheet S-2  
Part I  
Date/Time Prepared:  
11/30/2017 8:36 am

		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
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)		0.00	0.00			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)		0.00	0.00			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).		0.00	0.00			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)		0.00	0.00			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)		0.00	0.00			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 and enter in column 4, 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 and enter in column 4, direct GME FTE unweighted count.				0.00	0.00	61.20
							1.00
<b>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</b>							
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
<b>Teaching Hospitals that Claim Residents in Nonprovider Settings</b>							
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 64-67. (see instructions)					N	63.00
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
64.00	Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010. Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00
		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	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 14-0008

Period:  
From 07/01/2016  
To 06/30/2017

Worksheet S-2  
Part I  
Date/Time Prepared:  
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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
			1.00	2.00	3.00	
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

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	
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
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<b>Inpatient Psychiatric Facility PPS</b>						
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 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
<b>Inpatient Rehabilitation Facility PPS</b>						
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

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		1.00	2.00	3.00	
76.00	If line 75 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			
<b>Long Term Care Hospital PPS</b>					
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
<b>TEFRA Providers</b>					
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 a "subclause (II)" LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter "Y" for yes or "N" for no.		N		87.00
		V		XIX	
		1.00		2.00	
<b>Title V and XIX Services</b>					
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
<b>Rural Providers</b>					
105.00	Does this hospital qualify as a critical access hospital (CAH)?		N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)				106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.				107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		N		108.00
		Physical	Occupational	Speech	Respiratory
		1.00	2.00	3.00	4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.		N	N	N
		1.00			
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter "Y" for yes or "N" for no.			N	110.00
		1.00	2.00	3.00	
<b>Miscellaneous Cost Reporting Information</b>					
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.	Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	1			118.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0008	Period: From 07/01/2016 To 06/30/2017	Worksheet S-2 Part I Date/Time Prepared: 11/30/2017 8:36 am
		Premiums	Losses	Insurance
		1.00	2.00	3.00
118.01	List amounts of malpractice premiums and paid losses:	186,762	0	0
		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
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 state health or similar taxes? 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
<b>Transplant Center Information</b>				
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
<b>All Providers</b>				
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)		Y	902022
		1.00	2.00	3.00
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.				
141.00	Name: TRINITY HEALTH HOME OFFICE	Contractor's Name: WISCONSIN PHYSICIANS SERVICE		Contractor's Number: 08201
142.00	Street: 20555 VICTORY PARKWAY	PO Box:		
143.00	City: LIVONIA	State: MI	Zip Code: 48152	
			1.00	
144.00	Are provider based physicians' costs included in Worksheet A?		Y	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	N
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.		N	146.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 14-0008		Period: From 07/01/2016 To 06/30/2017		Worksheet S-2 Part I Date/Time Prepared: 11/30/2017 8:36 am		
1.00								
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.						Y	147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.						N	148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.						N	149.00
		Part A	Part B	Title V	Title XIX			
		1.00	2.00	3.00	4.00			
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)								
155.00	Hospital	N	N	N	N	N	155.00	
156.00	Subprovider - IPF	N	N	N	N	N	156.00	
157.00	Subprovider - IRF	N	N	N	N	N	157.00	
158.00	SUBPROVIDER						158.00	
159.00	SNF	N	N	N	N	N	159.00	
160.00	HOME HEALTH AGENCY	N	N	N	N	N	160.00	
161.00	CMHC		N	N	N	N	161.00	
161.10	CORF		N	N	N	N	161.10	
161.20	OUTPATIENT PHYSICAL THERAPY		N	N	N	N	161.20	
161.30	OUTPATIENT OCCUPATIONAL THERAPY		N	N	N	N	161.30	
161.40	OUTPATIENT SPEECH PATHOLOGY		N	N	N	N	161.40	
1.00								
Multi campus								
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.						N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	
1.00								
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act								
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.						Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)							168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						9.99	169.00
		Beginning	Ending					
		1.00	2.00					
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)		07/01/2016	06/30/2017				
		1.00	2.00					
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)						N	0
171.00								

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0008	Period: From 07/01/2016 To 06/30/2017	Worksheet S-2 Part II Date/Time Prepared: 11/30/2017 8:36 am		
			Y/N	Date		
			1.00	2.00		
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.						
COMPLETED BY ALL HOSPITALS						
Provider Organization and Operation						
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00	
			Y/N	Date	V/I	
			1.00	2.00	3.00	
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00	
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00	
			Y/N	Type	Date	
			1.00	2.00	3.00	
Financial Data and Reports						
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A	09/30/2017	4.00	
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00	
			Y/N	Legal Oper.		
			1.00	2.00		
Approved Educational Activities						
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00	
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00	
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00	
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	Y			9.00	
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00	
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00	
			Y/N			
			1.00			
Bad Debts						
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00	
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00	
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00	
Bed Complement						
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00	
			Part A		Part B	
			Y/N	Date	Y/N	Date
			1.00	2.00	3.00	4.00
PS&R Data						
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N		
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	11/08/2017	Y	11/08/2017	
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0008	Period: From 07/01/2016 To 06/30/2017	Worksheet S-2 Part II Date/Time Prepared: 11/30/2017 8:36 am	
		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	
<b>COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)</b>					
<b>Capital Related Cost</b>					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
<b>Interest Expense</b>					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
<b>Purchased Services</b>					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
<b>Provider-Based Physicians</b>					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
			Y/N	Date	
			1.00	2.00	
<b>Home Office Costs</b>					
36.00	Were home office costs claimed on the cost report?				36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
		1.00	2.00		
<b>Cost Report Preparer Contact Information</b>					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	DAVID		PALUCK	41.00
42.00	Enter the employer/company name of the cost report preparer.	LOYOLA UNIVERSITY HEALTH SYSTEM			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	708-216-6719		DAVID.D.PALUCK@TRI-NITY-HEALTH.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 14-0008	Period: From 07/01/2016 To 06/30/2017	Worksheet S-2 Part II Date/Time Prepared: 11/30/2017 8:36 am
		3.00		
<b>Cost Report Preparer Contact Information</b>				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	REGIONAL DIRECTOR OF REIMBURSEMENT		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0008

Period:  
From 07/01/2016  
To 06/30/2017

Worksheet S-3  
Part I  
Date/Time Prepared:  
11/30/2017 8:36 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Avai lable	CAH Hours	I/P Days / O/P Vi s i t s / Tri ps	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	131	51,065	0.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		131	51,065	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	24	8,760	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY					0	13.00
14.00 Total (see instructions)		155	59,825	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	12	4,380		0	16.00
17.00 SUBPROVIDER - IRF	41.00	21	7,665		0	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	44.00	34	12,410		0	19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	99.10				0	25.10
25.20 CMHC - OUTPATIENT PHYSICAL THERAPY	99.20				0	25.20
25.30 CMHC - OUTPATIENT OCCUPATIONAL THERAPY	99.30				0	25.30
25.40 CMHC - OUTPATIENT SPEECH PATHOLOGY	99.40				0	25.40
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		222				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	9,942	355	21,598			1.00
2.00 HMO and other (see instructions)	4,577	3,919				2.00
3.00 HMO IPF Subprovider	91	0				3.00
4.00 HMO IRF Subprovider	537	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	9,942	355	21,598			7.00
8.00 INTENSIVE CARE UNIT	1,799	80	3,786			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		22	527			13.00
14.00 Total (see instructions)	11,741	457	25,911	4.93	729.55	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF	2,758	5	2,839	0.00	15.37	16.00
17.00 SUBPROVIDER - IRF	2,797	652	5,777	0.00	30.73	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	6,360	211	9,007	0.00	35.44	19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	0	0	0	0.00	0.00	25.10
25.20 CMHC - OUTPATIENT PHYSICAL THERAPY	0	0	0	0.00	0.00	25.20
25.30 CMHC - OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0.00	0.00	25.30
25.40 CMHC - OUTPATIENT SPEECH PATHOLOGY	0	0	0	0.00	0.00	25.40
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00 Total (sum of lines 14-26)				4.93	811.09	27.00
28.00 Observation Bed Days		455	2,343			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			38			30.00
31.00 Employee discount days - IRF			45			31.00
32.00 Labor & delivery days (see instructions)	0	50	97			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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 14-0008

Period:  
From 07/01/2016  
To 06/30/2017

Worksheet S-3  
Part I  
Date/Time Prepared:  
11/30/2017 8:36 am

Component	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	2,548	1,004	5,972	1.00
2.00 HMO and other (see instructions)			842	0		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	2,548	1,004	5,972	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	176	1	192	16.00
17.00 SUBPROVIDER - IRF	0.00	0	239	52	466	17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	0.00					19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	0.00					25.10
25.20 CMHC - OUTPATIENT PHYSICAL THERAPY	0.00					25.20
25.30 CMHC - OUTPATIENT OCCUPATIONAL THERAPY	0.00					25.30
25.40 CMHC - OUTPATIENT SPEECH PATHOLOGY	0.00					25.40
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0008

Period:  
From 07/01/2016  
To 06/30/2017

Worksheet S-3  
Part II  
Date/Time Prepared:  
11/30/2017 8:36 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cat ion 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	
<b>PART II - WAGE DATA</b>							
<b>SALARIES</b>							
1.00	Total salaries (see instructions)	200.00	50,621,287	0	50,621,287	1,687,067.88	30.01
2.00	Non-physician anesthesiologist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthesiologist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician and Non-Physician-Part B		0	0	0	0.00	0.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	2,059,330	0	2,059,330	73,725.14	27.93
10.00	Excluded area salaries (see instructions)		3,631,378	0	3,631,378	113,222.92	32.07
<b>OTHER WAGES &amp; RELATED COSTS</b>							
11.00	Contract Labor: Direct Patient Care		1,397,824	0	1,397,824	21,029.00	66.47
12.00	Contract Labor: Top level management and other management and administrative services		0	0	0	0.00	0.00
13.00	Contract Labor: Physician-Part A - Administrative		0	0	0	0.00	0.00
14.00	Home office and/or related organization salaries and wage-related costs		0	0	0	0.00	0.00
14.01	Home office salaries		3,095,171	0	3,095,171	47,899.00	64.62
14.02	Related organization salaries		0	0	0	0.00	0.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
<b>WAGE-RELATED COSTS</b>							
17.00	Wage-related costs (core) (see instructions)		8,634,184	0	8,634,184		
18.00	Wage-related costs (other) (see instructions)		0	0	0		
19.00	Excluded areas		1,087,629	0	1,087,629		
20.00	Non-physician anesthesiologist Part A		0	0	0		
21.00	Non-physician anesthesiologist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FQHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
25.50	Home office wage-related		718,368	0	718,368		
25.51	Related organization wage-related		0	0	0		
25.52	Home office: Physician Part A - Administrative - wage-related		0	0	0		
25.53	Home office & Contract Physicians Part A - Teaching - wage-related		0	0	0		

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0008

Period:  
From 07/01/2016  
To 06/30/2017

Worksheet S-3  
Part II  
Date/Time Prepared:  
11/30/2017 8:36 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cat ion 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		
<b>OVERHEAD COSTS - DIRECT SALARIES</b>								
26.00	Employee Benefits Department	4.00	431,672	0	431,672	24,802.50	17.40	26.00
27.00	Administrative & General	5.00	4,456,781	0	4,456,781	156,039.78	28.56	27.00
28.00	Administrative & General under contract (see inst.)		51,149	0	51,149	1,578.00	32.41	28.00
29.00	Maintenance & Repairs	6.00	751,999	0	751,999	22,838.00	32.93	29.00
30.00	Operation of Plant	7.00	1,250,383	0	1,250,383	53,918.18	23.19	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	1,445,398	0	1,445,398	108,789.61	13.29	32.00
33.00	Housekeeping under contract (see instructions)		11,669	0	11,669	675.00	17.29	33.00
34.00	Dietary	10.00	929,583	-493,158	436,425	28,676.39	15.22	34.00
35.00	Dietary under contract (see instructions)		11,758	0	11,758	680.00	17.29	35.00
36.00	Cafeteria	11.00	165,352	493,158	658,510	44,754.23	14.71	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,829,901	0	1,829,901	36,592.76	50.01	38.00
39.00	Central Services and Supply	14.00	751,302	0	751,302	38,214.22	19.66	39.00
40.00	Pharmacy	15.00	2,157,003	0	2,157,003	48,296.70	44.66	40.00
41.00	Medical Records & Medical Records Library	16.00	1,066,134	0	1,066,134	53,674.42	19.86	41.00
42.00	Social Service	17.00	290,613	0	290,613	10,481.71	27.73	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 14-0008

Period:  
From 07/01/2016  
To 06/30/2017

Worksheet S-3  
Part III  
Date/Time Prepared:  
11/30/2017 8:36 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cat ion 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	
<b>PART III - HOSPITAL WAGE INDEX SUMMARY</b>							
1.00	Net salaries (see instructions)	50,695,863	0	50,695,863	1,690,000.88	30.00	1.00
2.00	Excluded area salaries (see instructions)	5,690,708	0	5,690,708	186,948.06	30.44	2.00
3.00	Subtotal salaries (line 1 minus line 2)	45,005,155	0	45,005,155	1,503,052.82	29.94	3.00
4.00	Subtotal other wages & related costs (see inst.)	4,492,995	0	4,492,995	68,928.00	65.18	4.00
5.00	Subtotal wage-related costs (see inst.)	9,352,552	0	9,352,552	0.00	20.78	5.00
6.00	Total (sum of lines 3 thru 5)	58,850,702	0	58,850,702	1,571,980.82	37.44	6.00
7.00	Total overhead cost (see instructions)	15,600,697	0	15,600,697	630,011.50	24.76	7.00

Provider CCN: 14-0008	Period: From 07/01/2016 To 06/30/2017	Worksheet S-3 Part IV Date/Time Prepared: 11/30/2017 8:36 am
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		Amount Reported	
		1.00	
<b>PART IV - WAGE RELATED COSTS</b>			
<b>Part A - Core List</b>			
<b>RETIREMENT COST</b>			
1.00	401K Employer Contributions	2,666,184	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	178,421	4.00
<b>PLAN ADMINISTRATIVE COSTS (Paid to External Organization)</b>			
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
<b>HEALTH AND INSURANCE COST</b>			
8.00	Health Insurance (Purchased or Self Funded)	2,125,794	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	0	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	118,578	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	38,892	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)	33,018	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	876,819	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
<b>TAXES</b>			
17.00	FICA-Employers Portion Only	2,860,044	17.00
18.00	Medicare Taxes - Employers Portion Only	668,881	18.00
19.00	Unemployment Insurance	66,256	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
<b>OTHER</b>			
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	88,925	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	9,721,812	24.00
<b>Part B - Other than Core Related Cost</b>			
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 14-0008	Period: From 07/01/2016 To 06/30/2017	Worksheet S-3 Part V Date/Time Prepared: 11/30/2017 8:36 am
Cost Center Description			Contract Labor	Benefit Cost
PART V - Contract Labor and Benefit Cost			1.00	2.00
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost		0	0 1.00
2.00	Hospital		0	0 2.00
3.00	Subprovider - IPF		0	0 3.00
4.00	Subprovider - IRF		0	0 4.00
5.00	Subprovider - (Other)		0	0 5.00
6.00	Swing Beds - SNF		0	0 6.00
7.00	Swing Beds - NF		0	0 7.00
8.00	Hospital-Based SNF		0	0 8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
16.10	Hospital-Based-CMHC 10		0	0 16.10
16.20	Hospital-Based-CMHC 20		0	0 16.20
16.30	Hospital-Based-CMHC 30		0	0 16.30
16.40	Hospital-Based-CMHC 40		0	0 16.40
17.00	Renal Dialysis		0	0 17.00
18.00	Other		0	0 18.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 14-0008

Period:  
From 07/01/2016  
To 06/30/2017

Worksheet S-7

Date/Time Prepared:  
11/30/2017 8:36 am

		1.00	2.00		
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.	N			1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	N			2.00
		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)
		1.00	2.00	3.00	4.00
3.00		RUX	0	0	3.00
4.00		RUL	0	0	4.00
5.00		RVX	0	0	5.00
6.00		RVL	0	0	6.00
7.00		RHX	0	0	7.00
8.00		RHL	0	0	8.00
9.00		RMX	0	0	9.00
10.00		RML	0	0	10.00
11.00		RLX	0	0	11.00
12.00		RUC	841	0	12.00
13.00		RUB	2,972	0	13.00
14.00		RUA	815	0	14.00
15.00		RVC	148	0	15.00
16.00		RVB	956	0	16.00
17.00		RVA	426	0	17.00
18.00		RHC	14	0	18.00
19.00		RHB	45	0	19.00
20.00		RHA	27	0	20.00
21.00		RMC	0	0	21.00
22.00		RMB	13	0	22.00
23.00		RMA	0	0	23.00
24.00		RLB	0	0	24.00
25.00		RLA	0	0	25.00
26.00		ES3	0	0	26.00
27.00		ES2	0	0	27.00
28.00		ES1	0	0	28.00
29.00		HE2	0	0	29.00
30.00		HE1	0	0	30.00
31.00		HD2	0	0	31.00
32.00		HD1	0	0	32.00
33.00		HC2	0	0	33.00
34.00		HC1	0	0	34.00
35.00		HB2	0	0	35.00
36.00		HB1	0	0	36.00
37.00		LE2	0	0	37.00
38.00		LE1	0	0	38.00
39.00		LD2	4	0	39.00
40.00		LD1	4	0	40.00
41.00		LC2	0	0	41.00
42.00		LC1	0	0	42.00
43.00		LB2	0	0	43.00
44.00		LB1	0	0	44.00
45.00		CE2	0	0	45.00
46.00		CE1	0	0	46.00
47.00		CD2	3	0	47.00
48.00		CD1	0	0	48.00
49.00		CC2	10	0	49.00
50.00		CC1	15	0	50.00
51.00		CB2	10	0	51.00
52.00		CB1	14	0	52.00
53.00		CA2	0	0	53.00
54.00		CA1	11	0	54.00
55.00		SE3	0	0	55.00
56.00		SE2	0	0	56.00
57.00		SE1	0	0	57.00
58.00		SSC	0	0	58.00
59.00		SSB	0	0	59.00
60.00		SSA	0	0	60.00
61.00		IB2	0	0	61.00
62.00		IB1	0	0	62.00
63.00		IA2	0	0	63.00
64.00		IA1	0	0	64.00
65.00		BB2	0	0	65.00
66.00		BB1	0	0	66.00
67.00		BA2	0	0	67.00
68.00		BA1	0	0	68.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 14-0008

Period:  
From 07/01/2016  
To 06/30/2017

Worksheet S-7

Date/Time Prepared:  
11/30/2017 8:36 am

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	2	0	2	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	19	0	19	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	8	0	8	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	3	0	3	199.00
200.00	TOTAL		6,360	0	6,360	200.00

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)	
		1.00	2.00	

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

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?	
		1.00	2.00	3.00	

A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)

202.00	Staffing	0	0.00		202.00
203.00	Recruitment	0	0.00		203.00
204.00	Retention of employees	0	0.00		204.00
205.00	Training	550	0.01	Y	205.00
206.00	NON-TRAINING EXPENSES	3,400,401	41.25	Y	206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	8,244,054			207.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 14-0008	Period: From 07/01/2016 To 06/30/2017	Worksheet S-10 Date/Time Prepared: 11/30/2017 8:36 am
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				1.00		
<b>Uncompensated and indigent care cost computation</b>						
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.210913		1.00	
<b>Medicaid (see instructions for each line)</b>						
2.00	Net revenue from Medicaid		15,864,404		2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?				3.00	
4.00	If line 3 is yes, does line 2 include all DSH or supplemental payments from Medicaid?				4.00	
5.00	If line 4 is no, then enter DSH or supplemental payments from Medicaid		0		5.00	
6.00	Medicaid charges		82,624,124		6.00	
7.00	Medicaid cost (line 1 times line 6)		17,426,502		7.00	
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		1,562,098		8.00	
<b>Children's Health Insurance Program (CHIP) (see instructions for each line)</b>						
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	
<b>Other state or local government indigent care program (see instructions for each line)</b>						
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	
<b>Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)</b>						
17.00	Private grants, donations, or endowment income restricted to funding charity care		0		17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations		0		18.00	
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		1,562,098		19.00	
				Uninsured patients	Insured patients	Total (col. 1 + col. 2)
				1.00	2.00	3.00
<b>Uncompensated Care (see instructions for each line)</b>						
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	3,949,278	328,380	4,277,658	20.00	
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	832,954	328,380	1,161,334	21.00	
22.00	Payments received from patients for amounts previously written off as charity care	4,040	31,874	35,914	22.00	
23.00	Cost of charity care (line 21 minus line 22)	828,914	296,506	1,125,420	23.00	
				1.00		
24.00	Does the amount in 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?				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)			10,687,567	26.00	
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)			670,431	27.00	
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)			1,031,430	27.01	
28.00	Non-Medicare bad debt expense (line 26 minus line 27.01)			9,656,137	28.00	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)			2,397,604	29.00	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			3,523,024	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			5,085,122	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0008

Period:  
From 07/01/2016  
To 06/30/2017

Worksheet A  
Date/Time Prepared:  
11/30/2017 8:36 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassified (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)		
		1.00	2.00	3.00	4.00	5.00		
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT		9,838,535	9,838,535	-4,595,022	5,243,513	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	5,174,922	5,174,922	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	431,672	9,812,893	10,244,565	-16,336	10,228,229	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	4,456,781	16,977,964	21,434,745	-943,289	20,491,456	5.00
6.00	00600	MAINTENANCE & REPAIRS	751,999	1,912,292	2,664,291	-34	2,664,257	6.00
7.00	00700	OPERATION OF PLANT	1,250,383	2,984,704	4,235,087	-2,993	4,232,094	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	902,830	902,830	0	902,830	8.00
9.00	00900	HOUSEKEEPING	1,445,398	1,286,905	2,732,303	0	2,732,303	9.00
10.00	01000	DIETARY	929,583	995,655	1,925,238	-1,005,315	919,923	10.00
11.00	01100	CAFETERIA	165,352	450,745	616,097	1,005,315	1,621,412	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	1,829,901	246,729	2,076,630	-13	2,076,617	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	751,302	527,075	1,278,377	-1,253	1,277,124	14.00
15.00	01500	PHARMACY	2,157,003	3,179,432	5,336,435	-1,500,171	3,836,264	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,066,134	324,599	1,390,733	0	1,390,733	16.00
17.00	01700	SOCIAL SERVICE	290,613	191,149	481,762	0	481,762	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	363,363	363,363	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	8,529,840	1,126,465	9,656,305	-1,162,831	8,493,474	30.00
31.00	03100	INTENSIVE CARE UNIT	2,671,267	579,806	3,251,073	-528,677	2,722,396	31.00
40.00	04000	SUBPROVIDER - I/PF	929,132	27,159	956,291	-13,957	942,334	40.00
41.00	04100	SUBPROVIDER - I/RF	2,173,252	309,741	2,482,993	-87,556	2,395,437	41.00
43.00	04300	NURSERY	0	0	0	218,901	218,901	43.00
44.00	04400	SKILLED NURSING FACILITY	2,059,330	1,341,621	3,400,951	-110,596	3,290,355	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	3,372,931	10,371,570	13,744,501	-9,643,412	4,101,089	50.00
51.00	05100	RECOVERY ROOM	439,682	99,723	539,405	-45,160	494,245	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	566,585	60,646	627,231	-34,457	592,774	52.00
53.00	05300	ANESTHESIOLOGY	0	369,037	369,037	-333,059	35,978	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,501,375	206,292	1,707,667	-61,633	1,646,034	54.00
56.00	05600	RADIOISOTOPE	184,756	273,702	458,458	-265,474	192,984	56.00
56.01	03630	ULTRASOUND	518,736	39,679	558,415	-36,733	521,682	56.01
57.00	05700	CT SCAN	456,156	145,121	601,277	-119,063	482,214	57.00
58.00	05800	MRI	198,907	164,205	363,112	-47,751	315,361	58.00
59.00	05900	CARDIAC CATHETERIZATION	562,319	1,123,772	1,686,091	-1,085,120	600,971	59.00
60.00	06000	LABORATORY	2,236,141	2,624,399	4,860,540	438,474	5,299,014	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,040,372	187,561	1,227,933	-113,927	1,114,006	65.00
66.00	06600	PHYSICAL THERAPY	2,184,110	25,662	2,209,772	-12,973	2,196,799	66.00
67.00	06700	OCCUPATIONAL THERAPY	260,353	2,173	262,526	-1,673	260,853	67.00
68.00	06800	SPEECH PATHOLOGY	209,990	58,086	268,076	-55,341	212,735	68.00
69.00	06900	ELECTROCARDIOLOGY	398,234	106,776	505,010	-40,970	464,040	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	95,700	5,823	101,523	-5,488	96,035	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	7,430,587	7,430,587	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	6,407,500	6,407,500	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	1,288,510	1,288,510	73.00
73.01	07301	OUTPATIENT PHARMACY	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	517,780	517,780	74.00
76.00	03950	LI THOTRI PSY	0	0	0	0	0	76.00
76.01	03951	CARDIAC REHABILITATION	236,311	6,056	242,367	-4,044	238,323	76.01
76.02	03020	GASTROINTESTINAL SERVICES	614,793	547,641	1,162,434	-322,396	840,038	76.02
76.03	03030	ANGIOCARDIOGRAPHY	0	0	0	0	0	76.03
76.05	03954	INPATIENT RENAL DIALYSIS	0	0	0	0	0	76.05
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LI THOTRI PSY	0	0	0	0	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES	0	0	0	0	0	90.01
90.02	04950	WOUND CARE	304,204	537,597	841,801	-123,635	718,166	90.02
90.03	09003	RIVER FOREST	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	2,821,696	1,213,403	4,035,099	-525,000	3,510,099	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0008

Period:  
From 07/01/2016  
To 06/30/2017

Worksheet A  
Date/Time Prepared:  
11/30/2017 8:36 am

Cost Center Description			Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1-117)	50,092,293	71,185,223	121,277,516	0	121,277,516	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	27,954	100,195	128,149	0	128,149	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	NON-EMPLOYEE CHILD CARE CENTER	0	0	0	0	0	192.01
192.02	19202	OUTPATIENT PHARMACY	328,366	1,196,214	1,524,580	0	1,524,580	192.02
192.03	19203	WEST TOWN PHO	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	23,573	23,573	0	23,573	193.00
193.01	19301	ADULT DAY CARE	172,394	19,322	191,716	0	191,716	193.01
194.00	07950	DISCONTINUED HOME HEALTH AND HOSPICE	280	16,276	16,556	0	16,556	194.00
200.00		TOTAL (SUM OF LINES 118-199)	50,621,287	72,540,803	123,162,090	0	123,162,090	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0008

Period:  
From 07/01/2016  
To 06/30/2017

Worksheet A  
Date/Time Prepared:  
11/30/2017 8:36 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-561,142	4,682,371	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	5,174,922	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-554,918	9,673,311	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-2,989,027	17,502,429	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	2,664,257	6.00
7.00	00700	OPERATION OF PLANT	0	4,232,094	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	902,830	8.00
9.00	00900	HOUSEKEEPING	0	2,732,303	9.00
10.00	01000	DIETARY	-68,684	851,239	10.00
11.00	01100	CAFETERIA	-199,565	1,421,847	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	-870	2,075,747	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,277,124	14.00
15.00	01500	PHARMACY	0	3,836,264	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-18,662	1,372,071	16.00
17.00	01700	SOCIAL SERVICE	919,149	1,400,911	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	363,363	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	0	8,493,474	30.00
31.00	03100	INTENSIVE CARE UNIT	0	2,722,396	31.00
40.00	04000	SUBPROVIDER - I PF	0	942,334	40.00
41.00	04100	SUBPROVIDER - I RF	0	2,395,437	41.00
43.00	04300	NURSERY	0	218,901	43.00
44.00	04400	SKILLED NURSING FACILITY	0	3,290,355	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0	4,101,089	50.00
51.00	05100	RECOVERY ROOM	0	494,245	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	592,774	52.00
53.00	05300	ANESTHESIOLOGY	0	35,978	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,646,034	54.00
56.00	05600	RADIO SOTOPE	0	192,984	56.00
56.01	03630	ULTRASOUND	0	521,682	56.01
57.00	05700	CT SCAN	0	482,214	57.00
58.00	05800	MRI	-66	315,295	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	600,971	59.00
60.00	06000	LABORATORY	0	5,299,014	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	1,114,006	65.00
66.00	06600	PHYSICAL THERAPY	0	2,196,799	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	260,853	67.00
68.00	06800	SPEECH PATHOLOGY	0	212,735	68.00
69.00	06900	ELECTROCARDIOLOGY	0	464,040	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	96,035	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	7,430,587	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	6,407,500	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	1,288,510	73.00
73.01	07301	OUTPATIENT PHARMACY	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	517,780	74.00
76.00	03950	LI THOTRI PSY	0	0	76.00
76.01	03951	CARDIAC REHABILITATION	0	238,323	76.01
76.02	03020	GASTROINTESTINAL SERVICES	0	840,038	76.02
76.03	03030	ANGIOCARDIOGRAPHY	0	0	76.03
76.05	03954	INPATIENT RENAL DIALYSIS	0	0	76.05
76.97	07697	CARDIAC REHABILITATION	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99	07699	LI THOTRI PSY	0	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	0	0	90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES	0	0	90.01
90.02	04950	WOUND CARE	0	718,166	90.02
90.03	09003	RIVER FOREST	0	0	90.03
91.00	09100	EMERGENCY	-2,122	3,507,977	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
99.10	09910	CORF	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	99.30

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 14-0008

Period:  
From 07/01/2016  
To 06/30/2017

Worksheet A  
Date/Time Prepared:  
11/30/2017 8:36 am

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation	
		6.00	7.00	
99.40	09940 OUTPATIENT SPEECH PATHOLOGY	0	0	99.40
SPECIAL PURPOSE COST CENTERS				
118.00	SUBTOTALS (SUM OF LINES 1-117)	-3,475,907	117,801,609	118.00
NONREIMBURSABLE COST CENTERS				
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	128,149	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	192.00
192.01	19201 NON-EMPLOYEE CHILD CARE CENTER	0	0	192.01
192.02	19202 OUTPATIENT PHARMACY	0	1,524,580	192.02
192.03	19203 WEST TOWN PHO	0	0	192.03
193.00	19300 NONPAID WORKERS	0	23,573	193.00
193.01	19301 ADULT DAY CARE	0	191,716	193.01
194.00	07950 DISCONTINUED HOME HEALTH AND HOSPICE	0	16,556	194.00
200.00	TOTAL (SUM OF LINES 118-199)	-3,475,907	119,686,183	200.00

		Increases			
Cost Center		Line #	Salary	Other	
2.00	3.00	4.00	5.00		
<b>A - Drugs Charged to Patients</b>					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	1,288,693	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00
27.00		0.00	0	0	27.00
0			0	1,288,693	
<b>B - Renal Dialysis Purchased Services</b>					
1.00	RENAL DIALYSIS	74.00	0	517,780	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
0			0	517,780	
<b>C - Dietary Shared Cost</b>					
1.00	CAFETERIA	11.00	493,158	512,157	1.00
0			493,158	512,157	
<b>E - Interns and Residents</b>					
1.00	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	0	363,363	1.00
0			0	363,363	
<b>F - Blood Transfusion</b>					
1.00	LABORATORY	60.00	0	529,266	1.00
0			0	529,266	
<b>I - Medical Supplies Charged to Patients</b>					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	7,436,868	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
0			0	7,436,868	

		Increases				
Cost Center		Line #	Salary	Other		
2.00		3.00	4.00	5.00		
<b>L - Implantable Devices</b>						
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	6,407,500	1.00	
2.00		0.00	0	0	2.00	
3.00		0.00	0	0	3.00	
4.00		0.00	0	0	4.00	
5.00		0.00	0	0	5.00	
6.00		0.00	0	0	6.00	
7.00		0.00	0	0	7.00	
8.00		0.00	0	0	8.00	
9.00		0.00	0	0	9.00	
	0		0	6,407,500		
<b>M - Nursery</b>						
1.00	NURSERY	43.00	210,238	8,663	1.00	
2.00		0.00	0	0	2.00	
3.00		0.00	0	0	3.00	
	0		210,238	8,663		
<b>N - Capital Movable Equipment</b>						
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	5,174,922	1.00	
	TOTALS		0	5,174,922		
<b>O - Interest Expense</b>						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	579,900	1.00	
	TOTALS		0	579,900		
500.00	Grand Total: Increases		703,396	22,819,112	500.00	

RECLASSIFICATIONS

Provider CCN: 14-0008

Period:  
From 07/01/2016  
To 06/30/2017

Worksheet A-6  
Date/Time Prepared:  
11/30/2017 8:36 am

		Decreases					
Cost Center		Line #	Salary	Other	Wkst. A-7 Ref.		
6.00	7.00	8.00	9.00	10.00			
<b>A - Drugs Charged to Patients</b>							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	16,336	0		1.00
2.00	MAINTENANCE & REPAIRS	6.00	0	34	0		2.00
3.00	OPERATION OF PLANT	7.00	0	2,904	0		3.00
4.00	NURSING ADMINISTRATION	13.00	0	13	0		4.00
5.00	CENTRAL SERVICES & SUPPLY	14.00	0	476	0		5.00
6.00	PHARMACY	15.00	0	970,722	0		6.00
7.00	ADULTS & PEDIATRICS	30.00	0	43,566	0		7.00
8.00	INTENSIVE CARE UNIT	31.00	0	14,195	0		8.00
9.00	SUBPROVIDER - IPF	40.00	0	259	0		9.00
10.00	SKILLED NURSING FACILITY	44.00	0	3,146	0		10.00
11.00	OPERATING ROOM	50.00	0	108,243	0		11.00
12.00	RECOVERY ROOM	51.00	0	2,901	0		12.00
13.00	DELIVERY ROOM & LABOR ROOM	52.00	0	2,432	0		13.00
14.00	ANESTHESIOLOGY	53.00	0	17,073	0		14.00
15.00	RADIOLOGY-DIAGNOSTIC	54.00	0	2,377	0		15.00
16.00	RADIOISOTOPE	56.00	0	252	0		16.00
17.00	ULTRASOUND	56.01	0	313	0		17.00
18.00	CT SCAN	57.00	0	12,448	0		18.00
19.00	MRI	58.00	0	34,666	0		19.00
20.00	CARDIAC CATHETERIZATION	59.00	0	2,513	0		20.00
21.00	LABORATORY	60.00	0	17	0		21.00
22.00	RESPIRATORY THERAPY	65.00	0	2,595	0		22.00
23.00	PHYSICAL THERAPY	66.00	0	205	0		23.00
24.00	ELECTROCARDIOLOGY	69.00	0	194	0		24.00
25.00	GASTROINTESTINAL SERVICES	76.02	0	12,211	0		25.00
26.00	WOUND CARE	90.02	0	241	0		26.00
27.00	EMERGENCY	91.00	0	38,361	0		27.00
0			0	1,288,693			
<b>B - Renal Dialysis Purchased Services</b>							
1.00	ADULTS & PEDIATRICS	30.00	0	299,773	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	130,451	0		2.00
3.00	SUBPROVIDER - IRF	41.00	0	87,556	0		3.00
0			0	517,780			
<b>C - Dietary Shared Cost</b>							
1.00	DIETARY	10.00	493,158	512,157	0		1.00
0			493,158	512,157			
<b>E - Interns and Residents</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	363,363	0		1.00
0			0	363,363			
<b>F - Blood Transfusion</b>							
1.00	PHARMACY	15.00	0	529,266	0		1.00
0			0	529,266			
<b>I - Medical Supplies Charged to Patients</b>							
1.00	ADULTS & PEDIATRICS	30.00	0	607,055	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	384,031	0		2.00
3.00	SUBPROVIDER - IPF	40.00	0	13,698	0		3.00
4.00	SKILLED NURSING FACILITY	44.00	0	107,450	0		4.00
5.00	OPERATING ROOM	50.00	0	3,575,098	0		5.00
6.00	RECOVERY ROOM	51.00	0	42,259	0		6.00
7.00	DELIVERY ROOM & LABOR ROOM	52.00	0	32,025	0		7.00
8.00	ANESTHESIOLOGY	53.00	0	315,986	0		8.00
9.00	RADIOLOGY-DIAGNOSTIC	54.00	0	59,256	0		9.00
10.00	RADIOISOTOPE	56.00	0	265,222	0		10.00
11.00	ULTRASOUND	56.01	0	36,420	0		11.00
12.00	CT SCAN	57.00	0	106,615	0		12.00
13.00	MRI	58.00	0	13,085	0		13.00
14.00	CARDIAC CATHETERIZATION	59.00	0	682,536	0		14.00
15.00	LABORATORY	60.00	0	90,686	0		15.00
16.00	RESPIRATORY THERAPY	65.00	0	111,332	0		16.00
17.00	PHYSICAL THERAPY	66.00	0	12,768	0		17.00
18.00	OCCUPATIONAL THERAPY	67.00	0	1,673	0		18.00
19.00	SPEECH PATHOLOGY	68.00	0	55,341	0		19.00
20.00	ELECTROCARDIOLOGY	69.00	0	40,776	0		20.00
21.00	ELECTROENCEPHALOGRAPHY	70.00	0	5,488	0		21.00
22.00	CARDIAC REHABILITATION	76.01	0	4,044	0		22.00
23.00	GASTROINTESTINAL SERVICES	76.02	0	304,585	0		23.00
24.00	WOUND CARE	90.02	0	82,800	0		24.00
25.00	EMERGENCY	91.00	0	486,639	0		25.00
0			0	7,436,868			
<b>L - Implantable Devices</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	26	0		1.00
2.00	OPERATION OF PLANT	7.00	0	89	0		2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	777	0		3.00

Decreases							
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
4.00	PHARMACY	15.00	0	183	0	4.00	
5.00	OPERATING ROOM	50.00	0	5,960,071	0	5.00	
6.00	CARDIAC CATHETERIZATION	59.00	0	400,071	0	6.00	
7.00	LABORATORY	60.00	0	89	0	7.00	
8.00	GASTROINTESTINAL SERVICES	76.02	0	5,600	0	8.00	
9.00	WOUND CARE	90.02	0	40,594	0	9.00	
			0	6,407,500			
<b>M - Nursery</b>							
1.00	ADULTS & PEDIATRICS	30.00	210,238	2,199	0	1.00	
2.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	6,281	0	2.00	
3.00	DRUGS CHARGED TO PATIENTS	73.00	0	183	0	3.00	
			210,238	8,663			
<b>N - Capital Movable Equipment</b>							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	5,174,922	9	1.00	
	TOTALS		0	5,174,922			
<b>O - Interest Expense</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	579,900	11	1.00	
	TOTALS		0	579,900			
500.00	Grand Total: Decreases		703,396	22,819,112		500.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0008

Period:  
From 07/01/2016  
To 06/30/2017

Worksheet A-7  
Part I  
Date/Time Prepared:  
11/30/2017 8:36 am

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
		1.00	2.00	3.00		
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	12,500,000	0	0	0	1.00
2.00	Land Improvements	987,143	10,031	0	10,031	2.00
3.00	Buildings and Fixtures	54,865,049	814	0	814	3.00
4.00	Building Improvements	0	0	0	0	4.00
5.00	Fixed Equipment	10,859,841	3,653,801	0	3,653,801	5.00
6.00	Movable Equipment	40,908,443	3,472,316	0	3,472,316	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	120,120,476	7,136,962	0	7,136,962	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	120,120,476	7,136,962	0	7,136,962	10.00
	Ending Balance		Fully Depreciated Assets			
	6.00		7.00			
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	12,500,000	0			1.00
2.00	Land Improvements	997,174	0			2.00
3.00	Buildings and Fixtures	54,865,863	0			3.00
4.00	Building Improvements	0	0			4.00
5.00	Fixed Equipment	14,513,642	0			5.00
6.00	Movable Equipment	43,896,670	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	126,773,349	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	126,773,349	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0008

Period:  
From 07/01/2016  
To 06/30/2017

Worksheet A-7  
Part II  
Date/Time Prepared:  
11/30/2017 8:36 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	9,838,535	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	9,838,535	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	9,838,535				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	9,838,535				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 14-0008

Period:  
From 07/01/2016  
To 06/30/2017

Worksheet A-7  
Part III  
Date/Time Prepared:  
11/30/2017 8:36 am

Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	82,884,678	0	82,884,678	0.653761	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	43,896,670	0	43,896,670	0.346239	0	2.00
3.00	Total (sum of lines 1-2)	126,781,348	0	126,781,348	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	4,663,613	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	5,174,922	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	9,838,535	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	18,758	0	0	0	4,682,371	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	5,174,922	2.00
3.00	Total (sum of lines 1-2)	18,758	0	0	0	9,857,293	3.00

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted				
			Cost Center	Line #	Wkst. A-7 Ref.		
			1.00	2.00	3.00	4.00	5.00
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00 Investment income - other (chapter 2)			0		0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)			0		0.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)			0		0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)			0		0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)	A	-47,214		ADMINISTRATIVE & GENERAL	5.00	0	7.00
8.00 Television and radio service (chapter 21)			0		0.00	0	8.00
9.00 Parking lot (chapter 21)			0		0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-24,773				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	7,044,338				0	12.00
13.00 Laundry and linen service			0		0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-199,534		CAFETERIA	11.00	0	14.00
15.00 Rental of quarters to employees and others			0		0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients			0		0.00	0	16.00
17.00 Sale of drugs to other than patients			0		0.00	0	17.00
18.00 Sale of medical records and abstracts	B	-18,662		MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00 Nursing school (tuition, fees, books, etc.)			0		0.00	0	19.00
20.00 Vending machines	B	-31		CAFETERIA	11.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)			0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0	RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0	PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0	*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT			0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00 Non-physician Anesthetist			0	NONPHYSICIAN ANESTHETISTS	19.00		28.00
29.00 Physicians' assistant			0		0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	OCCUPATIONAL THERAPY	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)			0	ADULTS & PEDIATRICS	30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	SPEECH PATHOLOGY	68.00		31.00

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
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
35.07 MISC INCOME A&G	B	-3,750,844	ADMINISTRATIVE & GENERAL	5.00	0	35.07	
35.15 WEST TOWNS 958.729	A	-423,717	ADMINISTRATIVE & GENERAL	5.00	0	35.15	
35.19 EMPLOYEE DAY CARE REVENUE	B	-489,281	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	35.19	
35.20 Emergency Room - FFA Revenue	B	-2,122	EMERGENCY	91.00	0	35.20	
37.00 DIETARY	B	-68,684	DIETARY	10.00	0	37.00	
39.00 BPCI Gain/Loss	A	919,149	SOCIAL SERVICE	17.00	0	39.00	
40.00 Grants & Gifts	A	-3,908	ADMINISTRATIVE & GENERAL	5.00	0	40.00	
41.00 ADVERTISING	A	-149,594	ADMINISTRATIVE & GENERAL	5.00	0	41.00	
41.01 ADVERTISING	A	-66	MRI	58.00	0	41.01	
42.00 MISC NURSING DEVELOPMENT	B	-870	NURSING ADMINISTRATION	13.00	0	42.00	
42.01 HAI P/ACA PROGRAM BENEFIT OFFSET	A	-6,260,094	ADMINISTRATIVE & GENERAL	5.00	0	42.01	
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-3,475,907					50.00

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

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

Provider CCN: 14-0008

Period: From 07/01/2016 To 06/30/2017

Worksheet A-8-1

Date/Time Prepared: 11/30/2017 8:36 am

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAI MED HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT		579,900	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	4,146,108	4,241,830	2.00
3.00	1.00	CAP REL COSTS-BLDG & FIXT	18,758	0	3.00
3.01	5.00	ADMINISTRATIVE & GENERAL	2,846,306	0	3.01
3.02	5.00	ADMINISTRATIVE & GENERAL	4,874,858	0	3.02
3.03	4.00	EMPLOYEE BENEFITS DEPARTMENT	876,819	1,015,494	3.03
3.04	5.00	ADMINISTRATIVE & GENERAL	143,436	0	3.04
3.05	5.00	ADMINISTRATIVE & GENERAL	75,253	0	3.05
3.07	4.00	EMPLOYEE BENEFITS DEPARTMENT	0	122,296	3.07
3.08	4.00	EMPLOYEE BENEFITS DEPARTMENT	178,421	-16,913	3.08
3.09	5.00	ADMINISTRATIVE & GENERAL	0	1,257,678	3.09
3.10	5.00	ADMINISTRATIVE & GENERAL	0	-1,084,664	3.10
4.00	0.00		0	0	4.00
5.00		TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.	13,159,959	6,115,621	5.00

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

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

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

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

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

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

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

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

Provider CCN: 14-0008

Period:  
From 07/01/2016  
To 06/30/2017

Worksheet A-8-1

Date/Time Prepared:  
11/30/2017 8:36 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>				
1.00	-579,900	11		1.00
2.00	-95,722	0		2.00
3.00	18,758	11		3.00
3.01	2,846,306	0		3.01
3.02	4,874,858	0		3.02
3.03	-138,675	0		3.03
3.04	143,436	0		3.04
3.05	75,253	0		3.05
3.07	-122,296	0		3.07
3.08	195,334	0		3.08
3.09	-1,257,678	0		3.09
3.10	1,084,664	0		3.10
4.00	0	0		4.00
5.00	7,044,338			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>B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:</b>		

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 14-0008

Period:  
From 07/01/2016  
To 06/30/2017

Worksheet A-8-2  
Date/Time Prepared:  
11/30/2017 8:36 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	24,773	24,773	0	211,500	0	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			24,773	24,773	0		0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	0.00		0	0	0	0	0	2.00
3.00	0.00		0	0	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			0	0	0	0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	24,773		1.00
2.00	0.00		0	0	0	0		2.00
3.00	0.00		0	0	0	0		3.00
4.00	0.00		0	0	0	0		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0		9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	24,773		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0008

Period:  
From 07/01/2016  
To 06/30/2017

Worksheet B  
Part I  
Date/Time Prepared:  
11/30/2017 8:36 am

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			
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	4,682,371	4,682,371			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	5,174,922		5,174,922		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	9,673,311	117,757	0	9,791,068	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	17,502,429	338,328	0	869,438	18,710,195
6.00 00600	MAINTENANCE & REPAIRS	2,664,257	26,247	0	146,701	2,837,205
7.00 00700	OPERATION OF PLANT	4,232,094	1,096,167	0	243,927	5,572,188
8.00 00800	LAUNDRY & LINEN SERVICE	902,830	18,043	0	0	920,873
9.00 00900	HOUSEKEEPING	2,732,303	23,834	0	281,971	3,038,108
10.00 01000	DIETARY	851,239	98,448	0	85,139	1,034,826
11.00 01100	CAFETERIA	1,421,847	85,245	0	128,463	1,635,555
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00 01300	NURSING ADMINISTRATION	2,075,747	27,316	0	356,981	2,460,044
14.00 01400	CENTRAL SERVICES & SUPPLY	1,277,124	105,583	0	146,565	1,529,272
15.00 01500	PHARMACY	3,836,264	36,179	0	420,792	4,293,235
16.00 01600	MEDICAL RECORDS & LIBRARY	1,372,071	36,826	0	207,984	1,616,881
17.00 01700	SOCIAL SERVICE	1,400,911	2,638	0	56,693	1,460,242
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0
20.00 02000	NURSING SCHOOL	0	0	0	0	0
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	363,363	0	0	0	363,363
23.00 02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	8,493,474	581,704	3,932,941	1,622,984	14,631,103
31.00 03100	INTENSIVE CARE UNIT	2,722,396	145,086	0	521,116	3,388,598
40.00 04000	SUBPROVIDER - I/PF	942,334	66,173	0	181,257	1,189,764
41.00 04100	SUBPROVIDER - I/RF	2,395,437	0	1,241,981	423,962	4,061,380
43.00 04300	NURSERY	218,901	17,067	0	41,014	276,982
44.00 04400	SKILLED NURSING FACILITY	3,290,355	158,513	0	401,738	3,850,606
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	4,101,089	421,529	0	657,998	5,180,616
51.00 05100	RECOVERY ROOM	494,245	20,009	0	85,774	600,028
52.00 05200	DELIVERY ROOM & LABOR ROOM	592,774	91,932	0	110,531	795,237
53.00 05300	ANESTHESIOLOGY	35,978	8,138	0	0	44,116
54.00 05400	RADIOLOGY-DIAGNOSTIC	1,646,034	132,451	0	292,891	2,071,376
56.00 05600	RADIOISOTOPE	192,984	25,087	0	36,043	254,114
56.01 03630	ULTRASOUND	521,682	25,245	0	101,196	648,123
57.00 05700	CT SCAN	482,214	16,065	0	88,988	587,267
58.00 05800	MRI	315,295	30,983	0	38,803	385,081
59.00 05900	CARDIAC CATHETERIZATION	600,971	27,210	0	109,698	737,879
60.00 06000	LABORATORY	5,299,014	129,496	0	436,231	5,864,741
62.30 06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0
65.00 06500	RESPIRATORY THERAPY	1,114,006	14,416	0	202,958	1,331,380
66.00 06600	PHYSICAL THERAPY	2,196,799	277,497	0	426,081	2,900,377
67.00 06700	OCCUPATIONAL THERAPY	260,853	21,829	0	50,790	333,472
68.00 06800	SPEECH PATHOLOGY	212,735	12,926	0	40,965	266,626
69.00 06900	ELECTROCARDIOLOGY	464,040	27,144	0	77,688	568,872
70.00 07000	ELECTROENCEPHALOGRAPHY	96,035	13,757	0	18,669	128,461
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	7,430,587	0	0	0	7,430,587
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	6,407,500	0	0	0	6,407,500
73.00 07300	DRUGS CHARGED TO PATIENTS	1,288,510	0	0	0	1,288,510
73.01 07301	OUTPATIENT PHARMACY	0	0	0	0	0
74.00 07400	RENAL DIALYSIS	517,780	0	0	0	517,780
76.00 03950	LI THOTRI PSY	0	0	0	0	0
76.01 03951	CARDIAC REHABILITATION	238,323	47,602	0	46,100	332,025
76.02 03020	GASTROINTESTINAL SERVICES	840,038	51,558	0	119,935	1,011,531
76.03 03030	ANGIOCARDIOGRAPHY	0	0	0	0	0
76.05 03954	INPATIENT RENAL DIALYSIS	0	0	0	0	0
76.97 07697	CARDIAC REHABILITATION	0	0	0	0	0
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0
76.99 07699	LI THOTRI PSY	0	0	0	0	0
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	0	1,213	0	0	1,213
90.01 09001	OUTPATIENT INFUSION PROCEDURES	0	0	0	0	0
90.02 04950	WOUND CARE	718,166	29,782	0	59,345	807,293
90.03 09003	RIVER FOREST	0	0	0	0	0
91.00 09100	EMERGENCY	3,507,977	150,204	0	550,462	4,208,643
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0008

Period:  
From 07/01/2016  
To 06/30/2017

Worksheet B  
Part I  
Date/Time Prepared:  
11/30/2017 8:36 am

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			
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.10 09910	CORF	0	0	0	0	99.10
99.20 09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	99.20
99.30 09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	99.30
99.40 09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	99.40
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1-117)	117,801,609	4,557,227	5,174,922	9,687,871	117,573,268 118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	128,149	57,771	0	5,453	191,373 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0 192.00
192.01 19201	NON-EMPLOYEE CHILD CARE CENTER	0	0	0	0	0 192.01
192.02 19202	OUTPATIENT PHARMACY	1,524,580	26,195	0	64,058	1,614,833 192.02
192.03 19203	WEST TOWN PHO	0	0	0	0	0 192.03
193.00 19300	NONPAID WORKERS	23,573	20,338	0	0	43,911 193.00
193.01 19301	ADULT DAY CARE	191,716	20,840	0	33,631	246,187 193.01
194.00 07950	DISCONTINUED HOME HEALTH AND HOSPICE	16,556	0	0	55	16,611 194.00
200.00	Cross Foot Adjustments					0 200.00
201.00	Negative Cost Centers		0	0	0	0 201.00
202.00	TOTAL (sum lines 118-201)	119,686,183	4,682,371	5,174,922	9,791,068	119,686,183 202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 14-0008	Period: From 07/01/2016 To 06/30/2017	Worksheet B Part I Date/Time Prepared: 11/30/2017 8:36 am
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Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING		
		5.00	6.00	7.00	8.00	9.00		
<b>GENERAL SERVICE COST CENTERS</b>								
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	18,710,195				5.00	
6.00	00600	MAINTENANCE & REPAIRS	525,717	3,362,922			6.00	
7.00	00700	OPERATION OF PLANT	1,032,493	877,687	7,482,368		7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	170,632	14,447	43,497	1,149,449	8.00	
9.00	00900	HOUSEKEEPING	562,943	19,083	57,455	405,891	4,083,480	9.00
10.00	01000	DIETARY	191,747	78,826	237,324	28,937	131,290	10.00
11.00	01100	CAFETERIA	303,059	68,255	205,496	0	113,683	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	455,831	21,871	65,849	0	36,428	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	283,365	84,539	254,525	0	140,806	14.00
15.00	01500	PHARMACY	795,511	28,968	87,216	0	48,249	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	299,598	29,486	88,774	0	49,111	16.00
17.00	01700	SOCIAL SERVICE	270,574	2,112	6,359	0	3,518	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	67,329	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	2,711,007	465,764	1,402,287	0	775,761	30.00
31.00	03100	INTENSIVE CARE UNIT	627,887	116,169	349,753	0	193,487	31.00
40.00	04000	SUBPROVIDER - IPF	220,456	52,984	159,519	0	88,248	40.00
41.00	04100	SUBPROVIDER - IRF	752,549	0	0	0	0	41.00
43.00	04300	NURSERY	51,323	13,666	41,144	0	22,761	43.00
44.00	04400	SKILLED NURSING FACILITY	713,494	126,920	382,121	0	211,394	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	959,937	337,513	1,016,161	714,532	562,151	50.00
51.00	05100	RECOVERY ROOM	111,182	16,021	48,234	0	26,684	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	147,353	73,609	221,616	0	122,601	52.00
53.00	05300	ANESTHESIOLOGY	8,174	6,516	19,618	0	10,853	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	383,814	106,052	319,293	0	176,636	54.00
56.00	05600	RADIO SOTOPE	47,086	20,087	60,476	0	33,456	56.00
56.01	03630	ULTRASOUND	120,093	20,213	60,857	0	33,667	56.01
57.00	05700	CT SCAN	108,817	12,863	38,727	0	21,424	57.00
58.00	05800	MRI	71,353	24,807	74,688	0	41,318	58.00
59.00	05900	CARDIAC CATHETERIZATION	136,725	21,787	65,595	0	36,288	59.00
60.00	06000	LABORATORY	1,086,701	103,686	312,171	0	172,696	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	246,697	11,543	34,753	0	19,226	65.00
66.00	06600	PHYSICAL THERAPY	537,422	222,189	668,951	0	370,071	66.00
67.00	06700	OCCUPATIONAL THERAPY	61,790	17,478	52,622	0	29,111	67.00
68.00	06800	SPEECH PATHOLOGY	49,404	10,350	31,160	0	17,238	68.00
69.00	06900	ELECTROCARDIOLOGY	105,409	21,734	65,436	0	36,200	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	23,803	11,015	33,163	0	18,346	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,376,843	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,187,271	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	238,753	0	0	0	0	73.00
73.01	07301	OUTPATIENT PHARMACY	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	95,942	0	0	0	0	74.00
76.00	03950	LI THOTRI PSY	0	0	0	0	0	76.00
76.01	03951	CARDIAC REHABILITATION	61,522	38,114	114,751	0	63,481	76.01
76.02	03020	GASTROINTESTINAL SERVICES	187,431	41,282	124,290	0	68,758	76.02
76.03	03030	ANGIOCARDIOGRAPHY	0	0	0	0	0	76.03
76.05	03954	INPATIENT RENAL DIALYSIS	0	0	0	0	0	76.05
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LI THOTRI PSY	0	0	0	0	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	225	972	2,925	0	1,618	90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES	0	0	0	0	0	90.01
90.02	04950	WOUND CARE	149,587	23,846	71,795	0	39,718	90.02
90.03	09003	RIVER FOREST	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	779,836	120,267	362,090	89	200,312	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0008

Period:  
From 07/01/2016  
To 06/30/2017

Worksheet B  
Part I  
Date/Time Prepared:  
11/30/2017 8:36 am

Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING						
		5.00	6.00	7.00	8.00	9.00						
SPECIAL PURPOSE COST CENTERS												
118.00		SUBTOTALS (SUM OF LINES 1-117)					18,318,685	3,262,721	7,180,691	1,149,449	3,916,589	118.00
NONREIMBURSABLE COST CENTERS												
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	35,460	46,256	139,265	0	77,043	190.00				
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00				
192.01	19201	NON-EMPLOYEE CHILD CARE CENTER	0	0	0	0	0	192.01				
192.02	19202	OUTPATIENT PHARMACY	299,219	20,974	63,146	0	34,933	192.02				
192.03	19203	WEST TOWN PHO	0	0	0	0	0	192.03				
193.00	19300	NONPAID WORKERS	8,136	16,285	49,029	0	27,123	193.00				
193.01	19301	ADULT DAY CARE	45,617	16,686	50,237	0	27,792	193.01				
194.00	07950	DISCONTINUED HOME HEALTH AND HOSPICE	3,078	0	0	0	0	194.00				
200.00		Cross Foot Adjustments						200.00				
201.00		Negative Cost Centers	0	0	0	0	0	201.00				
202.00		TOTAL (sum lines 118-201)	18,710,195	3,362,922	7,482,368	1,149,449	4,083,480	202.00				

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 14-0008		Period: From 07/01/2016 To 06/30/2017		Worksheet B Part I Date/Time Prepared: 11/30/2017 8:36 am	
Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATIVE	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	1,702,950					10.00
11.00	01100	CAFETERIA	0	2,326,048				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	67,458	0	3,107,481		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	73,546	0	0	2,366,053	14.00
15.00	01500	PHARMACY	0	92,710	0	0	32,087	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	102,089	0	32,631	854	16.00
17.00	01700	SOCIAL SERVICE	0	20,472	0	0	174	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	397	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	1,072,181	484,520	0	1,232,807	16,270	30.00
31.00	03100	INTENSIVE CARE UNIT	148,476	115,662	0	327,588	6,422	31.00
40.00	04000	SUBPROVIDER - I PF	110,636	59,567	0	131,803	827	40.00
41.00	04100	SUBPROVIDER - I RF	0	117,060	0	277,554	27,462	41.00
43.00	04300	NURSERY	20,654	11,273	0	28,664	1,004	43.00
44.00	04400	SKILLED NURSING FACILITY	351,003	141,726	0	305,322	3,145	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	174,372	0	231,231	70,411	50.00
51.00	05100	RECOVERY ROOM	0	19,390	0	47,219	359	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	29,986	0	68,845	340	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	4,490	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	99,113	0	17,531	1,691	54.00
56.00	05600	RADIOISOTOPE	0	7,621	0	0	282	56.00
56.01	03630	ULTRASOUND	0	23,268	0	0	364	56.01
57.00	05700	CT SCAN	0	22,185	0	0	3,196	57.00
58.00	05800	MRI	0	9,064	0	0	257	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	21,058	0	1,152	4,655	59.00
60.00	06000	LABORATORY	0	154,802	0	0	238,939	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	59,928	0	0	8,828	65.00
66.00	06600	PHYSICAL THERAPY	0	115,482	0	0	216	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	11,859	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	12,175	0	0	58	68.00
69.00	06900	ELECTROCARDIOLOGY	0	26,740	0	512	456	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	6,493	0	0	17	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	1,028,168	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	886,612	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	OUTPATIENT PHARMACY	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	LI THOTRI PSY	0	0	0	0	0	76.00
76.01	03951	CARDIAC REHABILITATION	0	10,146	0	11,005	164	76.01
76.02	03020	GASTROINTESTINAL SERVICES	0	33,639	0	58,224	6,489	76.02
76.03	03030	ANGIOCARDIOGRAPHY	0	0	0	0	0	76.03
76.05	03954	INPATIENT RENAL DIALYSIS	0	0	0	0	0	76.05
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LI THOTRI PSY	0	0	0	0	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES	0	0	0	0	0	90.01
90.02	04950	WOUND CARE	0	17,090	0	38,389	5,058	90.02
90.03	09003	RIVER FOREST	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	152,728	0	283,696	6,971	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description		DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY		
		10.00	11.00	12.00	13.00	14.00		
SPECIAL PURPOSE COST CENTERS								
118.00		SUBTOTALS (SUM OF LINES 1-117)						118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4,058	0	0	58	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	NON-EMPLOYEE CHILD CARE CENTER	0	0	0	0	0	192.01
192.02	19202	OUTPATIENT PHARMACY	0	16,819	0	0	8,845	192.02
192.03	19203	WEST TOWN PHO	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	117	193.00
193.01	19301	ADULT DAY CARE	0	11,949	0	13,308	111	193.01
194.00	07950	DISCONTINUED HOME HEALTH AND HOSPICE	0	0	0	0	259	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	1,702,950	2,326,048	0	3,107,481	2,366,053	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description		PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
		15.00	16.00	17.00	19.00	20.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
12.00	01200						12.00
13.00	01300						13.00
14.00	01400						14.00
15.00	01500	5,377,976					15.00
16.00	01600	0	2,219,424				16.00
17.00	01700	0	0	1,763,451			17.00
19.00	01900	0	0	0	0		19.00
20.00	02000	0	0	0	0	0	20.00
21.00	02100	0	0	0	0		21.00
22.00	02200	0	0	0	0		22.00
23.00	02300	0	0	0	0		23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	0	290,403	874,880	0	0	30.00
31.00	03100	0	57,551	153,361	0	0	31.00
40.00	04000	0	27,335	115,001	0	0	40.00
41.00	04100	4,988	28,355	234,011	0	0	41.00
43.00	04300	644	4,103	21,347	0	0	43.00
44.00	04400	0	33,471	364,851	0	0	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	0	103,888	0	0	0	50.00
51.00	05100	0	45,426	0	0	0	51.00
52.00	05200	0	8,864	0	0	0	52.00
53.00	05300	0	83,611	0	0	0	53.00
54.00	05400	0	81,823	0	0	0	54.00
56.00	05600	0	27,066	0	0	0	56.00
56.01	03630	0	45,242	0	0	0	56.01
57.00	05700	0	194,997	0	0	0	57.00
58.00	05800	0	53,747	0	0	0	58.00
59.00	05900	0	59,827	0	0	0	59.00
60.00	06000	0	348,259	0	0	0	60.00
62.30	06250	0	0	0	0	0	62.30
65.00	06500	0	46,968	0	0	0	65.00
66.00	06600	0	97,106	0	0	0	66.00
67.00	06700	0	21,054	0	0	0	67.00
68.00	06800	0	8,564	0	0	0	68.00
69.00	06900	0	70,225	0	0	0	69.00
70.00	07000	0	8,427	0	0	0	70.00
71.00	07100	0	40,020	0	0	0	71.00
72.00	07200	0	62,556	0	0	0	72.00
73.00	07300	4,522,338	95,682	0	0	0	73.00
73.01	07301	0	0	0	0	0	73.01
74.00	07400	0	2,756	0	0	0	74.00
76.00	03950	0	0	0	0	0	76.00
76.01	03951	0	4,283	0	0	0	76.01
76.02	03020	0	46,085	0	0	0	76.02
76.03	03030	0	0	0	0	0	76.03
76.05	03954	0	0	0	0	0	76.05
76.97	07697	0	0	0	0	0	76.97
76.98	07698	0	0	0	0	0	76.98
76.99	07699	0	0	0	0	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	0	56	0	0	0	90.00
90.01	09001	0	0	0	0	0	90.01
90.02	04950	0	13,447	0	0	0	90.02
90.03	09003	0	0	0	0	0	90.03
91.00	09100	0	208,227	0	0	0	91.00
92.00	09200	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	09910	0	0	0	0	0	99.10
99.20	09920	0	0	0	0	0	99.20
99.30	09930	0	0	0	0	0	99.30
99.40	09940	0	0	0	0	0	99.40

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description		PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL	
		15.00	16.00	17.00	19.00	20.00	
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	4,527,970	2,219,424	1,763,451	0	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201 NON-EMPLOYEE CHILD CARE CENTER	0	0	0	0	0	192.01
192.02	19202 OUTPATIENT PHARMACY	844,036	0	0	0	0	192.02
192.03	19203 WEST TOWN PHO	0	0	0	0	0	192.03
193.00	19300 NONPAID WORKERS	0	0	0	0	0	193.00
193.01	19301 ADULT DAY CARE	0	0	0	0	0	193.01
194.00	07950 DISCONTINUED HOME HEALTH AND HOSPICE	5,970	0	0	0	0	194.00
200.00	Cross Foot Adjustments					0	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	5,377,976	2,219,424	1,763,451	0	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

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Cost Center Description	INTERNS & RESIDENTS		PARAMED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments
	SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV			
	21.00	22.00			
<b>GENERAL SERVICE COST CENTERS</b>					
1.00 00100 CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00 00500 ADMINISTRATIVE & GENERAL					5.00
6.00 00600 MAINTENANCE & REPAIRS					6.00
7.00 00700 OPERATION OF PLANT					7.00
8.00 00800 LAUNDRY & LINEN SERVICE					8.00
9.00 00900 HOUSEKEEPING					9.00
10.00 01000 DIETARY					10.00
11.00 01100 CAFETERIA					11.00
12.00 01200 MAINTENANCE OF PERSONNEL					12.00
13.00 01300 NURSING ADMINISTRATION					13.00
14.00 01400 CENTRAL SERVICES & SUPPLY					14.00
15.00 01500 PHARMACY					15.00
16.00 01600 MEDICAL RECORDS & LIBRARY					16.00
17.00 01700 SOCIAL SERVICE					17.00
19.00 01900 NONPHYSICIAN ANESTHETISTS					19.00
20.00 02000 NURSING SCHOOL					20.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV	0				21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV		431,089			22.00
23.00 02300 PARAMED PRGM-(SPECIFY)			0		23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00 03000 ADULTS & PEDIATRICS	0	4,311	0	23,961,294	-4,311 30.00
31.00 03100 INTENSIVE CARE UNIT	0	0	0	5,484,954	0 31.00
40.00 04000 SUBPROVIDER - IPF	0	0	0	2,156,140	0 40.00
41.00 04100 SUBPROVIDER - IRF	0	0	0	5,503,359	0 41.00
43.00 04300 NURSERY	0	0	0	493,565	0 43.00
44.00 04400 SKILLED NURSING FACILITY	0	0	0	6,484,053	0 44.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00 05000 OPERATING ROOM	0	0	0	9,350,812	0 50.00
51.00 05100 RECOVERY ROOM	0	0	0	914,543	0 51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	1,468,451	0 52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	177,378	0 53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	3,257,329	0 54.00
56.00 05600 RADIO SOTOPE	0	0	0	450,188	0 56.00
56.01 03630 ULTRASOUND	0	0	0	951,827	0 56.01
57.00 05700 CT SCAN	0	0	0	989,476	0 57.00
58.00 05800 MRI	0	0	0	660,315	0 58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	1,084,966	0 59.00
60.00 06000 LABORATORY	0	0	0	8,281,995	0 60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0 62.30
65.00 06500 RESPIRATORY THERAPY	0	0	0	1,759,323	0 65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	4,911,814	0 66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	527,386	0 67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	395,575	0 68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	895,584	0 69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	229,725	0 70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	9,875,618	0 71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	8,543,939	0 72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	6,145,283	0 73.00
73.01 07301 OUTPATIENT PHARMACY	0	0	0	0	0 73.01
74.00 07400 RENAL DIALYSIS	0	0	0	616,478	0 74.00
76.00 03950 LI THOTRI PSY	0	0	0	0	0 76.00
76.01 03951 CARDIAC REHABILITATION	0	0	0	635,491	0 76.01
76.02 03020 GASTROINTESTINAL SERVICES	0	0	0	1,577,729	0 76.02
76.03 03030 ANGIOCARDIOGRAPHY	0	0	0	0	0 76.03
76.05 03954 INPATIENT RENAL DIALYSIS	0	0	0	0	0 76.05
76.97 07697 CARDIAC REHABILITATION	0	0	0	0	0 76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0	0	0	0 76.98
76.99 07699 LI THOTRI PSY	0	0	0	0	0 76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00 09000 CLINIC	0	0	0	7,009	0 90.00
90.01 09001 OUTPATIENT INFUSION PROCEDURES	0	0	0	0	0 90.01
90.02 04950 WOUND CARE	0	0	0	1,166,223	0 90.02
90.03 09003 RIVER FOREST	0	0	0	0	0 90.03
91.00 09100 EMERGENCY	0	426,778	0	6,749,637	-426,778 91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART					0 92.00

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Cost Center Description	INTERNS & RESIDENTS		PARAMED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments			
	SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV						
	21.00	22.00						
<b>OTHER REIMBURSABLE COST CENTERS</b>								
99.10 09910 CORF	0	0	0	0	0	99.10		
99.20 09920 OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20		
99.30 09930 OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30		
99.40 09940 OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40		
<b>SPECIAL PURPOSE COST CENTERS</b>								
118.00	SUBTOTALS (SUM OF LINES 1-117)		0	431,089	0	115,707,459	-431,089	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	493,513	0	190.00		
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00		
192.01 19201 NON-EMPLOYEE CHILD CARE CENTER	0	0	0	0	0	192.01		
192.02 19202 OUTPATIENT PHARMACY	0	0	0	2,902,805	0	192.02		
192.03 19203 WEST TOWN PHO	0	0	0	0	0	192.03		
193.00 19300 NONPAID WORKERS	0	0	0	144,601	0	193.00		
193.01 19301 ADULT DAY CARE	0	0	0	411,887	0	193.01		
194.00 07950 DISCONTINUED HOME HEALTH AND HOSPICE	0	0	0	25,918	0	194.00		
200.00	Cross Foot Adjustments		0	0	0	200.00		
201.00	Negative Cost Centers		0	0	0	201.00		
202.00	TOTAL (sum lines 118-201)		0	431,089	0	119,686,183	-431,089	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 14-0008	Period: From 07/01/2016 To 06/30/2017	Worksheet B Part I Date/Time Prepared: 11/30/2017 8:36 am
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Cost Center Description		Total	
		26.00	
<b>GENERAL SERVICE COST CENTERS</b>			
1.00	00100 CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500 ADMINISTRATIVE & GENERAL		5.00
6.00	00600 MAINTENANCE & REPAIRS		6.00
7.00	00700 OPERATION OF PLANT		7.00
8.00	00800 LAUNDRY & LINEN SERVICE		8.00
9.00	00900 HOUSEKEEPING		9.00
10.00	01000 DIETARY		10.00
11.00	01100 CAFETERIA		11.00
12.00	01200 MAINTENANCE OF PERSONNEL		12.00
13.00	01300 NURSING ADMINISTRATION		13.00
14.00	01400 CENTRAL SERVICES & SUPPLY		14.00
15.00	01500 PHARMACY		15.00
16.00	01600 MEDICAL RECORDS & LIBRARY		16.00
17.00	01700 SOCIAL SERVICE		17.00
19.00	01900 NONPHYSICIAN ANESTHETISTS		19.00
20.00	02000 NURSING SCHOOL		20.00
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRV		21.00
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV		22.00
23.00	02300 PARAMED ED PRGM-(SPECIFY)		23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>			
30.00	03000 ADULTS & PEDIATRICS	23,956,983	30.00
31.00	03100 INTENSIVE CARE UNIT	5,484,954	31.00
40.00	04000 SUBPROVIDER - IPF	2,156,140	40.00
41.00	04100 SUBPROVIDER - IRF	5,503,359	41.00
43.00	04300 NURSERY	493,565	43.00
44.00	04400 SKILLED NURSING FACILITY	6,484,053	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>			
50.00	05000 OPERATING ROOM	9,350,812	50.00
51.00	05100 RECOVERY ROOM	914,543	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1,468,451	52.00
53.00	05300 ANESTHESIOLOGY	177,378	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	3,257,329	54.00
56.00	05600 RADIO SOTOPE	450,188	56.00
56.01	03630 ULTRASOUND	951,827	56.01
57.00	05700 CT SCAN	989,476	57.00
58.00	05800 MRI	660,315	58.00
59.00	05900 CARDIAC CATHETERIZATION	1,084,966	59.00
60.00	06000 LABORATORY	8,281,995	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	62.30
65.00	06500 RESPIRATORY THERAPY	1,759,323	65.00
66.00	06600 PHYSICAL THERAPY	4,911,814	66.00
67.00	06700 OCCUPATIONAL THERAPY	527,386	67.00
68.00	06800 SPEECH PATHOLOGY	395,575	68.00
69.00	06900 ELECTROCARDIOLOGY	895,584	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	229,725	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	9,875,618	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	8,543,939	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	6,145,283	73.00
73.01	07301 OUTPATIENT PHARMACY	0	73.01
74.00	07400 RENAL DIALYSIS	616,478	74.00
76.00	03950 LI THOTRI PSY	0	76.00
76.01	03951 CARDIAC REHABILITATION	635,491	76.01
76.02	03020 GASTROINTESTINAL SERVICES	1,577,729	76.02
76.03	03030 ANGIOCARDIOGRAPHY	0	76.03
76.05	03954 INPATIENT RENAL DIALYSIS	0	76.05
76.97	07697 CARDIAC REHABILITATION	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	76.98
76.99	07699 LI THOTRI PSY	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>			
90.00	09000 CLINIC	7,009	90.00
90.01	09001 OUTPATIENT INFUSION PROCEDURES	0	90.01
90.02	04950 WOUND CARE	1,166,223	90.02
90.03	09003 RIVER FOREST	0	90.03
91.00	09100 EMERGENCY	6,322,859	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>			
99.10	09910 CORF	0	99.10
99.20	09920 OUTPATIENT PHYSICAL THERAPY	0	99.20
99.30	09930 OUTPATIENT OCCUPATIONAL THERAPY	0	99.30
99.40	09940 OUTPATIENT SPEECH PATHOLOGY	0	99.40
<b>SPECIAL PURPOSE COST CENTERS</b>			
118.00	SUBTOTALS (SUM OF LINES 1-117)	115,276,370	118.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 14-0008

Period:  
From 07/01/2016  
To 06/30/2017

Worksheet B  
Part I  
Date/Time Prepared:  
11/30/2017 8:36 am

Cost Center Description		Total	
		26.00	
<b>NONREIMBURSABLE COST CENTERS</b>			
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	493,513	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	192.00
192.01	19201 NON-EMPLOYEE CHILD CARE CENTER	0	192.01
192.02	19202 OUTPATIENT PHARMACY	2,902,805	192.02
192.03	19203 WEST TOWN PHO	0	192.03
193.00	19300 NONPAID WORKERS	144,601	193.00
193.01	19301 ADULT DAY CARE	411,887	193.01
194.00	07950 DISCONTINUED HOME HEALTH AND HOSPICE	25,918	194.00
200.00	Cross Foot Adjustments	0	200.00
201.00	Negative Cost Centers	0	201.00
202.00	TOTAL (sum lines 118-201)	119,255,094	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 14-0008		Period: From 07/01/2016 To 06/30/2017		Worksheet B Part II Date/Time Prepared: 11/30/2017 8:36 am	
Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT			
		BLDG & FIXT	MVBLE EQUIP					
		0	1.00				2.00	2A
<b>GENERAL SERVICE COST CENTERS</b>								
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	117,757	0	117,757	117,757	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	338,328	0	338,328	10,456	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	26,247	0	26,247	1,764	6.00
7.00	00700	OPERATION OF PLANT	0	1,096,167	0	1,096,167	2,933	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	18,043	0	18,043	0	8.00
9.00	00900	HOUSEKEEPING	0	23,834	0	23,834	3,391	9.00
10.00	01000	DIETARY	0	98,448	0	98,448	1,024	10.00
11.00	01100	CAFETERIA	0	85,245	0	85,245	1,545	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	27,316	0	27,316	4,293	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	105,583	0	105,583	1,763	14.00
15.00	01500	PHARMACY	0	36,179	0	36,179	5,060	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	36,826	0	36,826	2,501	16.00
17.00	01700	SOCIAL SERVICE	0	2,638	0	2,638	682	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	0	581,704	3,932,941	4,514,645	19,530	30.00
31.00	03100	INTENSIVE CARE UNIT	0	145,086	0	145,086	6,267	31.00
40.00	04000	SUBPROVIDER - I PF	0	66,173	0	66,173	2,180	40.00
41.00	04100	SUBPROVIDER - I RF	0	0	1,241,981	1,241,981	5,098	41.00
43.00	04300	NURSERY	0	17,067	0	17,067	493	43.00
44.00	04400	SKILLED NURSING FACILITY	0	158,513	0	158,513	4,831	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	421,529	0	421,529	7,913	50.00
51.00	05100	RECOVERY ROOM	0	20,009	0	20,009	1,031	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	91,932	0	91,932	1,329	52.00
53.00	05300	ANESTHESIOLOGY	0	8,138	0	8,138	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	132,451	0	132,451	3,522	54.00
56.00	05600	RADIOISOTOPE	0	25,087	0	25,087	433	56.00
56.01	03630	ULTRASOUND	0	25,245	0	25,245	1,217	56.01
57.00	05700	CT SCAN	0	16,065	0	16,065	1,070	57.00
58.00	05800	MRI	0	30,983	0	30,983	467	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	27,210	0	27,210	1,319	59.00
60.00	06000	LABORATORY	0	129,496	0	129,496	5,246	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	14,416	0	14,416	2,441	65.00
66.00	06600	PHYSICAL THERAPY	0	277,497	0	277,497	5,124	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	21,829	0	21,829	611	67.00
68.00	06800	SPEECH PATHOLOGY	0	12,926	0	12,926	493	68.00
69.00	06900	ELECTROCARDIOLOGY	0	27,144	0	27,144	934	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	13,757	0	13,757	225	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	OUTPATIENT PHARMACY	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	LI THOTRI PSY	0	0	0	0	0	76.00
76.01	03951	CARDIAC REHABILITATION	0	47,602	0	47,602	554	76.01
76.02	03020	GASTROINTESTINAL SERVICES	0	51,558	0	51,558	1,442	76.02
76.03	03030	ANGIOCARDIOGRAPHY	0	0	0	0	0	76.03
76.05	03954	INPATIENT RENAL DIALYSIS	0	0	0	0	0	76.05
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LI THOTRI PSY	0	0	0	0	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	1,213	0	1,213	0	90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES	0	0	0	0	0	90.01
90.02	04950	WOUND CARE	0	29,782	0	29,782	714	90.02
90.03	09003	RIVER FOREST	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	150,204	0	150,204	6,620	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
99.10	09910	CORF	0	0	0	0	0	99.10

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0008

Period:  
From 07/01/2016  
To 06/30/2017

Worksheet B  
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Date/Time Prepared:  
11/30/2017 8:36 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT		
		BLDG & FIXT	MVBLE EQUIP				
		0	1.00				2.00
99.20 09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30 09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40 09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
SPECIAL PURPOSE COST CENTERS							
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	4,557,227	5,174,922	9,732,149	116,516	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	57,771	0	57,771	66	190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01 19201	NON-EMPLOYEE CHILD CARE CENTER	0	0	0	0	0	192.01
192.02 19202	OUTPATIENT PHARMACY	0	26,195	0	26,195	770	192.02
192.03 19203	WEST TOWN PHO	0	0	0	0	0	192.03
193.00 19300	NONPAID WORKERS	0	20,338	0	20,338	0	193.00
193.01 19301	ADULT DAY CARE	0	20,840	0	20,840	404	193.01
194.00 07950	DISCONTINUED HOME HEALTH AND HOSPICE	0	0	0	0	1	194.00
200.00	Cross Foot Adjustments				0		200.00
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	4,682,371	5,174,922	9,857,293	117,757	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0008	Period: From 07/01/2016 To 06/30/2017	Worksheet B Part II Date/Time Prepared: 11/30/2017 8:36 am
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Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING		
		5.00	6.00	7.00	8.00	9.00		
<b>GENERAL SERVICE COST CENTERS</b>								
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	348,784				5.00	
6.00	00600	MAINTENANCE & REPAIRS	9,800	37,811			6.00	
7.00	00700	OPERATION OF PLANT	19,246	9,866	1,128,212		7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	3,181	162	6,559	27,945	8.00	
9.00	00900	HOUSEKEEPING	10,494	215	8,663	9,868	56,465	9.00
10.00	01000	DIETARY	3,574	886	35,784	703	1,815	10.00
11.00	01100	CAFETERIA	5,649	767	30,985	0	1,572	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	8,497	246	9,929	0	504	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	5,282	951	38,378	0	1,947	14.00
15.00	01500	PHARMACY	14,829	326	13,151	0	667	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	5,585	332	13,386	0	679	16.00
17.00	01700	SOCIAL SERVICE	5,044	24	959	0	49	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	1,255	0	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	50,546	5,237	211,441	0	10,728	30.00
31.00	03100	INTENSIVE CARE UNIT	11,704	1,306	52,737	0	2,675	31.00
40.00	04000	SUBPROVIDER - IPF	4,109	596	24,053	0	1,220	40.00
41.00	04100	SUBPROVIDER - IRF	14,028	0	0	0	0	41.00
43.00	04300	NURSERY	957	154	6,204	0	315	43.00
44.00	04400	SKILLED NURSING FACILITY	13,300	1,427	57,617	0	2,923	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	17,894	3,795	153,219	17,372	7,773	50.00
51.00	05100	RECOVERY ROOM	2,072	180	7,273	0	369	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,747	828	33,416	0	1,695	52.00
53.00	05300	ANESTHESIOLOGY	152	73	2,958	0	150	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,155	1,192	48,144	0	2,442	54.00
56.00	05600	RADIO SOTOPE	878	226	9,119	0	463	56.00
56.01	03630	ULTRASOUND	2,239	227	9,176	0	466	56.01
57.00	05700	CT SCAN	2,028	145	5,839	0	296	57.00
58.00	05800	MRI	1,330	279	11,262	0	571	58.00
59.00	05900	CARDIAC CATHETERIZATION	2,549	245	9,891	0	502	59.00
60.00	06000	LABORATORY	20,257	1,166	47,070	0	2,388	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	4,599	130	5,240	0	266	65.00
66.00	06600	PHYSICAL THERAPY	10,018	2,498	100,866	0	5,117	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,152	197	7,934	0	403	67.00
68.00	06800	SPEECH PATHOLOGY	921	116	4,698	0	238	68.00
69.00	06900	ELECTROCARDIOLOGY	1,965	244	9,867	0	501	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	444	124	5,000	0	254	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	25,665	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	22,132	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,451	0	0	0	0	73.00
73.01	07301	OUTPATIENT PHARMACY	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	1,788	0	0	0	0	74.00
76.00	03950	LI THOTRI PSY	0	0	0	0	0	76.00
76.01	03951	CARDIAC REHABILITATION	1,147	429	17,302	0	878	76.01
76.02	03020	GASTROINTESTINAL SERVICES	3,494	464	18,741	0	951	76.02
76.03	03030	ANGIOCARDIOGRAPHY	0	0	0	0	0	76.03
76.05	03954	INPATIENT RENAL DIALYSIS	0	0	0	0	0	76.05
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LI THOTRI PSY	0	0	0	0	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	4	11	441	0	22	90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES	0	0	0	0	0	90.01
90.02	04950	WOUND CARE	2,788	268	10,825	0	549	90.02
90.03	09003	RIVER FOREST	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	14,537	1,352	54,597	2	2,770	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0008			Period: From 07/01/2016 To 06/30/2017		Worksheet B Part II Date/Time Prepared: 11/30/2017 8:36 am	
Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING		
		5.00	6.00	7.00	8.00	9.00		
SPECIAL PURPOSE COST CENTERS								
118.00	SUBTOTALS (SUM OF LINES 1-117)		341,486	36,684	1,082,724	27,945	54,158	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	661	520	20,999	0	1,065	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	NON-EMPLOYEE CHILD CARE CENTER	0	0	0	0	0	192.01
192.02	19202	OUTPATIENT PHARMACY	5,578	236	9,521	0	483	192.02
192.03	19203	WEST TOWN PHO	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	152	183	7,393	0	375	193.00
193.01	19301	ADULT DAY CARE	850	188	7,575	0	384	193.01
194.00	07950	DISCONTINUED HOME HEALTH AND HOSPICE	57	0	0	0	0	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	348,784	37,811	1,128,212	27,945	56,465	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 14-0008		Period: From 07/01/2016 To 06/30/2017		Worksheet B Part II Date/Time Prepared: 11/30/2017 8:36 am	
Cost Center Description			DIETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	
			10.00	11.00	12.00	13.00	14.00	
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	142,234					10.00
11.00	01100	CAFETERIA	0	125,763				11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0			12.00
13.00	01300	NURSING ADMINISTRATION	0	3,647	0	54,432		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,976	0	0	157,880	14.00
15.00	01500	PHARMACY	0	5,013	0	0	2,141	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	5,520	0	572	57	16.00
17.00	01700	SOCIAL SERVICE	0	1,107	0	0	12	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	27	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	89,551	26,194	0	21,595	1,086	30.00
31.00	03100	INTENSIVE CARE UNIT	12,401	6,254	0	5,738	429	31.00
40.00	04000	SUBPROVIDER - I/PF	9,241	3,221	0	2,309	55	40.00
41.00	04100	SUBPROVIDER - I/RF	0	6,329	0	4,862	1,832	41.00
43.00	04300	NURSERY	1,725	610	0	502	67	43.00
44.00	04400	SKILLED NURSING FACILITY	29,316	7,663	0	5,348	210	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	9,428	0	4,050	4,698	50.00
51.00	05100	RECOVERY ROOM	0	1,048	0	827	24	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	1,621	0	1,206	23	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	300	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	5,359	0	307	113	54.00
56.00	05600	RADIOISOTOPE	0	412	0	0	19	56.00
56.01	03630	ULTRASOUND	0	1,258	0	0	24	56.01
57.00	05700	CT SCAN	0	1,200	0	0	213	57.00
58.00	05800	MRI	0	490	0	0	17	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,139	0	20	311	59.00
60.00	06000	LABORATORY	0	8,370	0	0	15,944	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	3,240	0	0	589	65.00
66.00	06600	PHYSICAL THERAPY	0	6,244	0	0	14	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	641	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	658	0	0	4	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,446	0	9	30	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	351	0	0	1	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	68,608	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	59,160	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	OUTPATIENT PHARMACY	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	LI THOTRI PSY	0	0	0	0	0	76.00
76.01	03951	CARDIAC REHABILITATION	0	549	0	193	11	76.01
76.02	03020	GASTROINTESTINAL SERVICES	0	1,819	0	1,020	433	76.02
76.03	03030	ANGIOCARDIOGRAPHY	0	0	0	0	0	76.03
76.05	03954	INPATIENT RENAL DIALYSIS	0	0	0	0	0	76.05
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LI THOTRI PSY	0	0	0	0	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES	0	0	0	0	0	90.01
90.02	04950	WOUND CARE	0	924	0	672	337	90.02
90.03	09003	RIVER FOREST	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	8,258	0	4,969	465	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
99.10	09910	CORF	0	0	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0008

Period:  
From 07/01/2016  
To 06/30/2017

Worksheet B  
Part II  
Date/Time Prepared:  
11/30/2017 8:36 am

Cost Center Description		DI ETARY	CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATIO N	CENTRAL SERVICES & SUPPLY		
		10.00	11.00	12.00	13.00	14.00		
SPECIAL PURPOSE COST CENTERS								
118.00	SUBTOTALS (SUM OF LINES 1-117)		142,234	123,989	0	54,199	157,254	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	219	0	0	4	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201	NON-EMPLOYEE CHILD CARE CENTER	0	0	0	0	0	192.01
192.02	19202	OUTPATIENT PHARMACY	0	909	0	0	590	192.02
192.03	19203	WEST TOWN PHO	0	0	0	0	0	192.03
193.00	19300	NONPAID WORKERS	0	0	0	0	8	193.00
193.01	19301	ADULT DAY CARE	0	646	0	233	7	193.01
194.00	07950	DISCONTINUED HOME HEALTH AND HOSPICE	0	0	0	0	17	194.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	142,234	125,763	0	54,432	157,880	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0008	Period: From 07/01/2016 To 06/30/2017	Worksheet B Part II Date/Time Prepared: 11/30/2017 8:36 am		
Cost Center Description		PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	NONPHYSICIAN ANESTHETISTS	NURSING SCHOOL
		15.00	16.00	17.00	19.00	20.00
<b>GENERAL SERVICE COST CENTERS</b>						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
6.00	00600	MAINTENANCE & REPAIRS				6.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
12.00	01200	MAINTENANCE OF PERSONNEL				12.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY	77,366			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	65,458		16.00
17.00	01700	SOCIAL SERVICE	0	0	10,515	17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	19.00
20.00	02000	NURSING SCHOOL	0	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00	03000	ADULTS & PEDIATRICS	0	8,581	5,217	30.00
31.00	03100	INTENSIVE CARE UNIT	0	1,701	914	31.00
40.00	04000	SUBPROVIDER - I PF	0	808	686	40.00
41.00	04100	SUBPROVIDER - I RF	72	838	1,395	41.00
43.00	04300	NURSERY	9	121	127	43.00
44.00	04400	SKILLED NURSING FACILITY	0	989	2,176	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	OPERATING ROOM	0	3,070	0	50.00
51.00	05100	RECOVERY ROOM	0	1,342	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	262	0	52.00
53.00	05300	ANESTHESIOLOGY	0	2,471	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,418	0	54.00
56.00	05600	RADIOISOTOPE	0	800	0	56.00
56.01	03630	ULTRASOUND	0	1,337	0	56.01
57.00	05700	CT SCAN	0	5,762	0	57.00
58.00	05800	MRI	0	1,588	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	1,768	0	59.00
60.00	06000	LABORATORY	0	10,166	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	1,388	0	65.00
66.00	06600	PHYSICAL THERAPY	0	2,869	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	622	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	253	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,075	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	249	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,183	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,848	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	65,057	2,827	0	73.00
73.01	07301	OUTPATIENT PHARMACY	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	81	0	74.00
76.00	03950	LITHOTRIPSY	0	0	0	76.00
76.01	03951	CARDIAC REHABILITATION	0	127	0	76.01
76.02	03020	GASTROINTESTINAL SERVICES	0	1,362	0	76.02
76.03	03030	ANGIOCARDIOGRAPHY	0	0	0	76.03
76.05	03954	INPATIENT RENAL DIALYSIS	0	0	0	76.05
76.97	07697	CARDIAC REHABILITATION	0	0	0	76.97
76.98	07698	HYPERBARIIC OXYGEN THERAPY	0	0	0	76.98
76.99	07699	LITHOTRIPSY	0	0	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00	09000	CLINIC	0	2	0	90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES	0	0	0	90.01
90.02	04950	WOUND CARE	0	397	0	90.02
90.03	09003	RIVER FOREST	0	0	0	90.03
91.00	09100	EMERGENCY	0	6,153	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.10	09910	CORF	0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	99.40

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0008			Period: From 07/01/2016 To 06/30/2017		Worksheet B Part II Date/Time Prepared: 11/30/2017 8:36 am	
Cost Center Description		PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	NONPHYSI CI AN ANESTHETI STS	NURSI NG SCHOO L		
		15.00	16.00	17.00	19.00	20.00		
SPECIAL PURPOSE COST CENTERS								
118.00	SUBTOTALS (SUM OF LINES 1-117)		65,138	65,458	10,515	0	0	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0			190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0			192.00
192.01	19201	NON-EMPLOYEE CHILD CARE CENTER	0	0	0			192.01
192.02	19202	OUTPATIENT PHARMACY	12,142	0	0			192.02
192.03	19203	WEST TOWN PHO	0	0	0			192.03
193.00	19300	NONPAID WORKERS	0	0	0			193.00
193.01	19301	ADULT DAY CARE	0	0	0			193.01
194.00	07950	DISCONTINUED HOME HEALTH AND HOSPICE	86	0	0			194.00
200.00		Cross Foot Adjustments				0		0200.00
201.00		Negative Cost Centers	0	0	0			0201.00
202.00		TOTAL (sum lines 118-201)	77,366	65,458	10,515	0		0202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0008	Period: From 07/01/2016 To 06/30/2017	Worksheet B Part II Date/Time Prepared: 11/30/2017 8:36 am
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Cost Center Description	INTERNS & RESIDENTS		PARAMED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments
	SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV			
	21.00	22.00			
<b>GENERAL SERVICE COST CENTERS</b>					
1.00 00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00 00500	ADMINISTRATIVE & GENERAL				5.00
6.00 00600	MAINTENANCE & REPAIRS				6.00
7.00 00700	OPERATION OF PLANT				7.00
8.00 00800	LAUNDRY & LINEN SERVICE				8.00
9.00 00900	HOUSEKEEPING				9.00
10.00 01000	DIETARY				10.00
11.00 01100	CAFETERIA				11.00
12.00 01200	MAINTENANCE OF PERSONNEL				12.00
13.00 01300	NURSING ADMINISTRATION				13.00
14.00 01400	CENTRAL SERVICES & SUPPLY				14.00
15.00 01500	PHARMACY				15.00
16.00 01600	MEDICAL RECORDS & LIBRARY				16.00
17.00 01700	SOCIAL SERVICE				17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS				19.00
20.00 02000	NURSING SCHOOL				20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0			21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV		1,282		22.00
23.00 02300	PARAMED PRGM-(SPECIFY)			0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00 03000	ADULTS & PEDIATRICS			4,964,351	0 30.00
31.00 03100	INTENSIVE CARE UNIT			247,212	0 31.00
40.00 04000	SUBPROVIDER - IPF			114,651	0 40.00
41.00 04100	SUBPROVIDER - IRF			1,276,435	0 41.00
43.00 04300	NURSERY			28,351	0 43.00
44.00 04400	SKILLED NURSING FACILITY			284,313	0 44.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00 05000	OPERATING ROOM			650,741	0 50.00
51.00 05100	RECOVERY ROOM			34,175	0 51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM			135,059	0 52.00
53.00 05300	ANESTHESIOLOGY			14,242	0 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC			203,103	0 54.00
56.00 05600	RADIO SOTOPE			37,437	0 56.00
56.01 03630	ULTRASOUND			41,189	0 56.01
57.00 05700	CT SCAN			32,618	0 57.00
58.00 05800	MRI			46,987	0 58.00
59.00 05900	CARDIAC CATHETERIZATION			44,954	0 59.00
60.00 06000	LABORATORY			240,103	0 60.00
62.30 06250	BLOOD CLOTTING FOR HEMOPHILIACS			0	0 62.30
65.00 06500	RESPIRATORY THERAPY			32,309	0 65.00
66.00 06600	PHYSICAL THERAPY			410,247	0 66.00
67.00 06700	OCCUPATIONAL THERAPY			33,389	0 67.00
68.00 06800	SPEECH PATHOLOGY			20,307	0 68.00
69.00 06900	ELECTROCARDIOLOGY			44,215	0 69.00
70.00 07000	ELECTROENCEPHALOGRAPHY			20,405	0 70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT			95,456	0 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS			83,140	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS			72,335	0 73.00
73.01 07301	OUTPATIENT PHARMACY			0	0 73.01
74.00 07400	RENAL DIALYSIS			1,869	0 74.00
76.00 03950	LI THOTRI PSY			0	0 76.00
76.01 03951	CARDIAC REHABILITATION			68,792	0 76.01
76.02 03020	GASTROINTESTINAL SERVICES			81,284	0 76.02
76.03 03030	ANGIOCARDIOGRAPHY			0	0 76.03
76.05 03954	INPATIENT RENAL DIALYSIS			0	0 76.05
76.97 07697	CARDIAC REHABILITATION			0	0 76.97
76.98 07698	HYPERBARIC OXYGEN THERAPY			0	0 76.98
76.99 07699	LI THOTRI PSY			0	0 76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00 09000	CLINIC			1,693	0 90.00
90.01 09001	OUTPATIENT INFUSION PROCEDURES			0	0 90.01
90.02 04950	WOUND CARE			47,256	0 90.02
90.03 09003	RIVER FOREST			0	0 90.03
91.00 09100	EMERGENCY			249,927	0 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART				0 92.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 14-0008

Period:  
From 07/01/2016  
To 06/30/2017

Worksheet B  
Part II  
Date/Time Prepared:  
11/30/2017 8:36 am

Cost Center Description	INTERNS & RESIDENTS			PARAMED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments		
	SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV						
	21.00	22.00	23.00					
<b>OTHER REIMBURSABLE COST CENTERS</b>								
99.10	09910	CORF				0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY				0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY				0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY				0	0	99.40
<b>SPECIAL PURPOSE COST CENTERS</b>								
118.00	SUBTOTALS (SUM OF LINES 1-117)		0	0	0	9,658,545	0	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN				81,305	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES				0	0	192.00
192.01	19201	NON-EMPLOYEE CHILD CARE CENTER				0	0	192.01
192.02	19202	OUTPATIENT PHARMACY				56,424	0	192.02
192.03	19203	WEST TOWN PHO				0	0	192.03
193.00	19300	NONPAID WORKERS				28,449	0	193.00
193.01	19301	ADULT DAY CARE				31,127	0	193.01
194.00	07950	DISCONTINUED HOME HEALTH AND HOSPICE				161	0	194.00
200.00		Cross Foot Adjustments	0	1,282	0	1,282	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	1,282	0	9,857,293	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0008	Period: From 07/01/2016 To 06/30/2017	Worksheet B Part II Date/Time Prepared: 11/30/2017 8:36 am
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Cost Center Description		Total		
		26.00		
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
6.00	00600	MAINTENANCE & REPAIRS		6.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
12.00	01200	MAINTENANCE OF PERSONNEL		12.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE		17.00
19.00	01900	NONPHYSICIAN ANESTHETISTS		19.00
20.00	02000	NURSING SCHOOL		20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV		22.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)		23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000	ADULTS & PEDIATRICS	4,964,351	30.00
31.00	03100	INTENSIVE CARE UNIT	247,212	31.00
40.00	04000	SUBPROVIDER - IPF	114,651	40.00
41.00	04100	SUBPROVIDER - IRF	1,276,435	41.00
43.00	04300	NURSERY	28,351	43.00
44.00	04400	SKILLED NURSING FACILITY	284,313	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000	OPERATING ROOM	650,741	50.00
51.00	05100	RECOVERY ROOM	34,175	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	135,059	52.00
53.00	05300	ANESTHESIOLOGY	14,242	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	203,103	54.00
56.00	05600	RADIOLOGY	37,437	56.00
56.01	03630	ULTRASOUND	41,189	56.01
57.00	05700	CT SCAN	32,618	57.00
58.00	05800	MRI	46,987	58.00
59.00	05900	CARDIAC CATHETERIZATION	44,954	59.00
60.00	06000	LABORATORY	240,103	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	62.30
65.00	06500	RESPIRATORY THERAPY	32,309	65.00
66.00	06600	PHYSICAL THERAPY	410,247	66.00
67.00	06700	OCCUPATIONAL THERAPY	33,389	67.00
68.00	06800	SPEECH PATHOLOGY	20,307	68.00
69.00	06900	ELECTROCARDIOLOGY	44,215	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	20,405	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	95,456	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	83,140	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	72,335	73.00
73.01	07301	OUTPATIENT PHARMACY	0	73.01
74.00	07400	RENAL DIALYSIS	1,869	74.00
76.00	03950	LI THOTRI PSY	0	76.00
76.01	03951	CARDIAC REHABILITATION	68,792	76.01
76.02	03020	GASTROINTESTINAL SERVICES	81,284	76.02
76.03	03030	ANGIOCARDIOGRAPHY	0	76.03
76.05	03954	INPATIENT RENAL DIALYSIS	0	76.05
76.97	07697	CARDIAC REHABILITATION	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	76.98
76.99	07699	LI THOTRI PSY	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>				
90.00	09000	CLINIC	1,693	90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES	0	90.01
90.02	04950	WOUND CARE	47,256	90.02
90.03	09003	RIVER FOREST	0	90.03
91.00	09100	EMERGENCY	249,927	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
99.10	09910	CORF	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	99.40
<b>SPECIAL PURPOSE COST CENTERS</b>				
118.00		SUBTOTALS (SUM OF LINES 1-117)	9,658,545	118.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 14-0008	Period: From 07/01/2016 To 06/30/2017	Worksheet B Part II Date/Time Prepared: 11/30/2017 8:36 am
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Cost Center Description		Total	
		26.00	
<b>NONREIMBURSABLE COST CENTERS</b>			
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	81,305	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	192.00
192.01	19201 NON-EMPLOYEE CHILD CARE CENTER	0	192.01
192.02	19202 OUTPATIENT PHARMACY	56,424	192.02
192.03	19203 WEST TOWN PHO	0	192.03
193.00	19300 NONPAID WORKERS	28,449	193.00
193.01	19301 ADULT DAY CARE	31,127	193.01
194.00	07950 DISCONTINUED HOME HEALTH AND HOSPICE	161	194.00
200.00	Cross Foot Adjustments	1,282	200.00
201.00	Negative Cost Centers	0	201.00
202.00	TOTAL (sum lines 118-201)	9,857,293	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0008

Period:  
From 07/01/2016  
To 06/30/2017

Worksheet B-1

Date/Time Prepared:  
11/30/2017 8:36 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP ((DOLLAR VALUE))				
	1.00	2.00				
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	355,003				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		25			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	8,928	0	50,189,615		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	25,651	0	4,456,781	-18,710,195	5.00
6.00 00600	MAINTENANCE & REPAIRS	1,990	0	751,999	0	6.00
7.00 00700	OPERATION OF PLANT	83,108	0	1,250,383	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	1,368	0	0	0	8.00
9.00 00900	HOUSEKEEPING	1,807	0	1,445,398	0	9.00
10.00 01000	DIETARY	7,464	0	436,425	0	10.00
11.00 01100	CAFETERIA	6,463	0	658,510	0	11.00
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00 01300	NURSING ADMINISTRATION	2,071	0	1,829,901	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	8,005	0	751,302	0	14.00
15.00 01500	PHARMACY	2,743	0	2,157,003	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	2,792	0	1,066,134	0	16.00
17.00 01700	SOCIAL SERVICE	200	0	290,613	0	17.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
20.00 02000	NURSING SCHOOL	0	0	0	0	20.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	22.00
23.00 02300	PARAMEDICAL PRGM-(SPECIFY)	0	0	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	44,103	19	8,319,602	0	30.00
31.00 03100	INTENSIVE CARE UNIT	11,000	0	2,671,267	0	31.00
40.00 04000	SUBPROVIDER - IPF	5,017	0	929,132	0	40.00
41.00 04100	SUBPROVIDER - IRF	0	6	2,173,252	0	41.00
43.00 04300	NURSERY	1,294	0	210,238	0	43.00
44.00 04400	SKILLED NURSING FACILITY	12,018	0	2,059,330	0	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	31,959	0	3,372,931	0	50.00
51.00 05100	RECOVERY ROOM	1,517	0	439,682	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	6,970	0	566,585	0	52.00
53.00 05300	ANESTHESIOLOGY	617	0	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	10,042	0	1,501,375	0	54.00
56.00 05600	RADIOISOTOPE	1,902	0	184,756	0	56.00
56.01 03630	ULTRASOUND	1,914	0	518,736	0	56.01
57.00 05700	CT SCAN	1,218	0	456,156	0	57.00
58.00 05800	MRI	2,349	0	198,907	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	2,063	0	562,319	0	59.00
60.00 06000	LABORATORY	9,818	0	2,236,141	0	60.00
62.30 06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	62.30
65.00 06500	RESPIRATORY THERAPY	1,093	0	1,040,372	0	65.00
66.00 06600	PHYSICAL THERAPY	21,039	0	2,184,110	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	1,655	0	260,353	0	67.00
68.00 06800	SPEECH PATHOLOGY	980	0	209,990	0	68.00
69.00 06900	ELECTROCARDIOLOGY	2,058	0	398,234	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	1,043	0	95,700	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
73.01 07301	OUTPATIENT PHARMACY	0	0	0	0	73.01
74.00 07400	RENAL DIALYSIS	0	0	0	0	74.00
76.00 03950	LI THOTRI PSY	0	0	0	0	76.00
76.01 03951	CARDIAC REHABILITATION	3,609	0	236,311	0	76.01
76.02 03020	GASTROINTESTINAL SERVICES	3,909	0	614,793	0	76.02
76.03 03030	ANGIOCARDIOGRAPHY	0	0	0	0	76.03
76.05 03954	INPATIENT RENAL DIALYSIS	0	0	0	0	76.05
76.97 07697	CARDIAC REHABILITATION	0	0	0	0	76.97
76.98 07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	76.98
76.99 07699	LI THOTRI PSY	0	0	0	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000	CLINIC	92	0	0	0	90.00
90.01 09001	OUTPATIENT INFUSION PROCEDURES	0	0	0	0	90.01
90.02 04950	WOUND CARE	2,258	0	304,204	0	90.02
90.03 09003	RIVER FOREST	0	0	0	0	90.03
91.00 09100	EMERGENCY	11,388	0	2,821,696	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0008

Period:  
From 07/01/2016  
To 06/30/2017

Worksheet B-1

Date/Time Prepared:  
11/30/2017 8:36 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM COST)			
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP ((DOLLAR VALUE))						
	1.00	2.00					4.00	5A
OTHER REIMBURSABLE COST CENTERS								
99.10 09910 CORF	0	0	0	0	0	99.10		
99.20 09920 OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20		
99.30 09930 OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30		
99.40 09940 OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40		
SPECIAL PURPOSE COST CENTERS								
118.00	SUBTOTALS (SUM OF LINES 1-117)		345,515	25	49,660,621	-18,710,195	98,863,073	118.00
NONREIMBURSABLE COST CENTERS								
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,380	0	27,954	0	191,373	190.00		
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00		
192.01 19201 NON-EMPLOYEE CHILD CARE CENTER	0	0	0	0	0	192.01		
192.02 19202 OUTPATIENT PHARMACY	1,986	0	328,366	0	1,614,833	192.02		
192.03 19203 WEST TOWN PHO	0	0	0	0	0	192.03		
193.00 19300 NONPAID WORKERS	1,542	0	0	0	43,911	193.00		
193.01 19301 ADULT DAY CARE	1,580	0	172,394	0	246,187	193.01		
194.00 07950 DISCONTINUED HOME HEALTH AND HOSPICE	0	0	280	0	16,611	194.00		
200.00	Cross Foot Adjustments					200.00		
201.00	Negative Cost Centers					201.00		
202.00	Cost to be allocated (per Wkst. B, Part I)	4,682,371	5,174,922	9,791,068	18,710,195	202.00		
203.00	Unit cost multiplier (Wkst. B, Part I)	13.189666	206,996.88000	0.195082	0.185294	203.00		
204.00	Cost to be allocated (per Wkst. B, Part II)			117,757	348,784	204.00		
205.00	Unit cost multiplier (Wkst. B, Part II)			0.002346	0.003454	205.00		

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0008

Period:  
From 07/01/2016  
To 06/30/2017

Worksheet B-1  
Date/Time Prepared:  
11/30/2017 8:36 am

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE ((POUNDS OF LAUNDRY))	HOUSEKEEPING (SQUARE FEET)	DIETARY ((MEALS SERVED))	
		6.00	7.00	8.00	9.00	10.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600	318,434					6.00
7.00	00700	83,108	235,326				7.00
8.00	00800	1,368	1,368	991,122			8.00
9.00	00900	1,807	1,807	349,983	232,151		9.00
10.00	01000	7,464	7,464	24,951	7,464	131,097	10.00
11.00	01100	6,463	6,463	0	6,463	0	11.00
12.00	01200	0	0	0	0	0	12.00
13.00	01300	2,071	2,071	0	2,071	0	13.00
14.00	01400	8,005	8,005	0	8,005	0	14.00
15.00	01500	2,743	2,743	0	2,743	0	15.00
16.00	01600	2,792	2,792	0	2,792	0	16.00
17.00	01700	200	200	0	200	0	17.00
19.00	01900	0	0	0	0	0	19.00
20.00	02000	0	0	0	0	0	20.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
23.00	02300	0	0	0	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	44,103	44,103	0	44,103	82,539	30.00
31.00	03100	11,000	11,000	0	11,000	11,430	31.00
40.00	04000	5,017	5,017	0	5,017	8,517	40.00
41.00	04100	0	0	0	0	0	41.00
43.00	04300	1,294	1,294	0	1,294	1,590	43.00
44.00	04400	12,018	12,018	0	12,018	27,021	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	31,959	31,959	616,111	31,959	0	50.00
51.00	05100	1,517	1,517	0	1,517	0	51.00
52.00	05200	6,970	6,970	0	6,970	0	52.00
53.00	05300	617	617	0	617	0	53.00
54.00	05400	10,042	10,042	0	10,042	0	54.00
56.00	05600	1,902	1,902	0	1,902	0	56.00
56.01	03630	1,914	1,914	0	1,914	0	56.01
57.00	05700	1,218	1,218	0	1,218	0	57.00
58.00	05800	2,349	2,349	0	2,349	0	58.00
59.00	05900	2,063	2,063	0	2,063	0	59.00
60.00	06000	9,818	9,818	0	9,818	0	60.00
62.30	06250	0	0	0	0	0	62.30
65.00	06500	1,093	1,093	0	1,093	0	65.00
66.00	06600	21,039	21,039	0	21,039	0	66.00
67.00	06700	1,655	1,655	0	1,655	0	67.00
68.00	06800	980	980	0	980	0	68.00
69.00	06900	2,058	2,058	0	2,058	0	69.00
70.00	07000	1,043	1,043	0	1,043	0	70.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	0	0	73.00
73.01	07301	0	0	0	0	0	73.01
74.00	07400	0	0	0	0	0	74.00
76.00	03950	0	0	0	0	0	76.00
76.01	03951	3,609	3,609	0	3,609	0	76.01
76.02	03020	3,909	3,909	0	3,909	0	76.02
76.03	03030	0	0	0	0	0	76.03
76.05	03954	0	0	0	0	0	76.05
76.97	07697	0	0	0	0	0	76.97
76.98	07698	0	0	0	0	0	76.98
76.99	07699	0	0	0	0	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	92	92	0	92	0	90.00
90.01	09001	0	0	0	0	0	90.01
90.02	04950	2,258	2,258	0	2,258	0	90.02
90.03	09003	0	0	0	0	0	90.03
91.00	09100	11,388	11,388	77	11,388	0	91.00
92.00	09200						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	09910	0	0	0	0	0	99.10
99.20	09920	0	0	0	0	0	99.20
99.30	09930	0	0	0	0	0	99.30

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0008

Period:  
From 07/01/2016  
To 06/30/2017

Worksheet B-1

Date/Time Prepared:  
11/30/2017 8:36 am

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE ((POUNDS OF LAUNDRY))	HOUSEKEEPING (SQUARE FEET)	DIETARY ((MEALS SERVED))	
99.40	09940 OUTPATIENT SPEECH PATHOLOGY	6.00	7.00	8.00	9.00	10.00	0
	SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	99.40
118.00	SUBTOTALS (SUM OF LINES 1-117)	308,946	225,838	991,122	222,663	131,097	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	4,380	4,380	0	4,380	0	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01	19201 NON-EMPLOYEE CHILD CARE CENTER	0	0	0	0	0	192.01
192.02	19202 OUTPATIENT PHARMACY	1,986	1,986	0	1,986	0	192.02
192.03	19203 WEST TOWN PHO	0	0	0	0	0	192.03
193.00	19300 NONPAID WORKERS	1,542	1,542	0	1,542	0	193.00
193.01	19301 ADULT DAY CARE	1,580	1,580	0	1,580	0	193.01
194.00	07950 DISCONTINUED HOME HEALTH AND HOSPICE	0	0	0	0	0	194.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	3,362,922	7,482,368	1,149,449	4,083,480	1,702,950	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	10.560813	31.795756	1.159745	17.589758	12.990000	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	37,811	1,128,212	27,945	56,465	142,234	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.118740	4.794251	0.028195	0.243225	1.084952	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0008

Period:  
From 07/01/2016  
To 06/30/2017

Worksheet B-1  
Date/Time Prepared:  
11/30/2017 8:36 am

Cost Center Description		CAFETERIA ((FTES SERVED))	MAINTENANCE OF PERSONNEL ((FTES SERVED))	NURSING ADMINISTRATION ((FTES SERVED))	CENTRAL SERVICES & SUPPLY ((COSTED REQUIS))	PHARMACY ((COSTED REQUIS))	
		11.00	12.00	13.00	14.00	15.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	51,584					11.00
12.00	01200	0	0				12.00
13.00	01300	1,496	0	24,284			13.00
14.00	01400	1,631	0	0	17,099,395		14.00
15.00	01500	2,056	0	0	231,890	1,528,841	15.00
16.00	01600	2,264	0	255	6,169	0	16.00
17.00	01700	454	0	0	1,254	0	17.00
19.00	01900	0	0	0	0	0	19.00
20.00	02000	0	0	0	0	0	20.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	2,872	0	22.00
23.00	02300	0	0	0	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	10,745	0	9,634	117,579	0	30.00
31.00	03100	2,565	0	2,560	46,410	0	31.00
40.00	04000	1,321	0	1,030	5,976	0	40.00
41.00	04100	2,596	0	2,169	198,467	1,418	41.00
43.00	04300	250	0	224	7,255	183	43.00
44.00	04400	3,143	0	2,386	22,726	0	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	3,867	0	1,807	508,856	0	50.00
51.00	05100	430	0	369	2,594	0	51.00
52.00	05200	665	0	538	2,457	0	52.00
53.00	05300	0	0	0	32,449	0	53.00
54.00	05400	2,198	0	137	12,222	0	54.00
56.00	05600	169	0	0	2,038	0	56.00
56.01	03630	516	0	0	2,631	0	56.01
57.00	05700	492	0	0	23,099	0	57.00
58.00	05800	201	0	0	1,860	0	58.00
59.00	05900	467	0	9	33,638	0	59.00
60.00	06000	3,433	0	0	1,726,798	0	60.00
62.30	06250	0	0	0	0	0	62.30
65.00	06500	1,329	0	0	63,799	0	65.00
66.00	06600	2,561	0	0	1,559	0	66.00
67.00	06700	263	0	0	0	0	67.00
68.00	06800	270	0	0	417	0	68.00
69.00	06900	593	0	4	3,295	0	69.00
70.00	07000	144	0	0	126	0	70.00
71.00	07100	0	0	0	7,430,588	0	71.00
72.00	07200	0	0	0	6,407,500	0	72.00
73.00	07300	0	0	0	0	1,285,602	73.00
73.01	07301	0	0	0	0	0	73.01
74.00	07400	0	0	0	0	0	74.00
76.00	03950	0	0	0	0	0	76.00
76.01	03951	225	0	86	1,182	0	76.01
76.02	03020	746	0	455	46,899	0	76.02
76.03	03030	0	0	0	0	0	76.03
76.05	03954	0	0	0	0	0	76.05
76.97	07697	0	0	0	0	0	76.97
76.98	07698	0	0	0	0	0	76.98
76.99	07699	0	0	0	0	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	0	0	0	0	0	90.00
90.01	09001	0	0	0	0	0	90.01
90.02	04950	379	0	300	36,551	0	90.02
90.03	09003	0	0	0	0	0	90.03
91.00	09100	3,387	0	2,217	50,377	0	91.00
92.00	09200						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	09910	0	0	0	0	0	99.10
99.20	09920	0	0	0	0	0	99.20

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0008

Period:  
From 07/01/2016  
To 06/30/2017

Worksheet B-1

Date/Time Prepared:  
11/30/2017 8:36 am

Cost Center Description		CAFETERIA ((FTES SERVED))	MAINTENANCE OF PERSONNEL ((FTES SERVED))	NURSING ADMINISTRATION ((FTES SERVED))	CENTRAL SERVICES & SUPPLY ((COSTED REQUIS))	PHARMACY ((COSTED REQUIS))		
		11.00	12.00	13.00	14.00	15.00		
99.30	09930	0	0	0	0	0	99.30	
99.40	09940	0	0	0	0	0	99.40	
SPECIAL PURPOSE COST CENTERS								
118.00	SUBTOTALS (SUM OF LINES 1-117)		50,856	0	24,180	17,031,533	1,287,203	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	90	0	0	422	0	190.00	
192.00	19200	0	0	0	0	0	192.00	
192.01	19201	0	0	0	0	0	192.01	
192.02	19202	373	0	0	63,920	239,941	192.02	
192.03	19203	0	0	0	0	0	192.03	
193.00	19300	0	0	0	843	0	193.00	
193.01	19301	265	0	104	803	0	193.01	
194.00	07950	0	0	0	1,874	1,697	194.00	
200.00	Cross Foot Adjustments							200.00
201.00	Negative Cost Centers							201.00
202.00	Cost to be allocated (per Wkst. B, Part I)		2,326,048	0	3,107,481	2,366,053	5,377,976	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)		45.092432	0.000000	127.964133	0.138371	3.517682	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)		125,763	0	54,432	157,880	77,366	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)		2.438023	0.000000	2.241476	0.009233	0.050604	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0008

Period:  
From 07/01/2016  
To 06/30/2017

Worksheet B-1

Date/Time Prepared:  
11/30/2017 8:36 am

Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS	SERVICES-SALARY & FRINGES APPRV ((ASSIGNED TIME))
	16.00	17.00	19.00	20.00	21.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00 00500 ADMINISTRATIVE & GENERAL						5.00
6.00 00600 MAINTENANCE & REPAIRS						6.00
7.00 00700 OPERATION OF PLANT						7.00
8.00 00800 LAUNDRY & LINEN SERVICE						8.00
9.00 00900 HOUSEKEEPING						9.00
10.00 01000 DIETARY						10.00
11.00 01100 CAFETERIA						11.00
12.00 01200 MAINTENANCE OF PERSONNEL						12.00
13.00 01300 NURSING ADMINISTRATION						13.00
14.00 01400 CENTRAL SERVICES & SUPPLY						14.00
15.00 01500 PHARMACY						15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	546,559,071					16.00
17.00 01700 SOCIAL SERVICE	0	43,534				17.00
19.00 01900 NONPHYSICIAN ANESTHETISTS	0	0	0			19.00
20.00 02000 NURSING SCHOOL	0	0		0		20.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0			100	21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0				22.00
23.00 02300 PARAMED ED PRGM-(SPECIFY)	0	0				23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000 ADULTS & PEDIATRICS	71,510,100	21,598	0	0		30.00
31.00 03100 INTENSIVE CARE UNIT	14,171,593	3,786	0	0		31.00
40.00 04000 SUBPROVIDER - I/PF	6,730,992	2,839	0	0		40.00
41.00 04100 SUBPROVIDER - I/RF	6,982,303	5,777	0	0		41.00
43.00 04300 NURSERY	1,010,332	527	0	0		43.00
44.00 04400 SKILLED NURSING FACILITY	8,242,107	9,007	0	0		44.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	25,581,986	0	0	0		50.00
51.00 05100 RECOVERY ROOM	11,185,865	0	0	0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	2,182,688	0	0	0		52.00
53.00 05300 ANESTHESIOLOGY	20,588,650	0	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	20,148,417	0	0	0		54.00
56.00 05600 RADIO SOTOPE	6,664,937	0	0	0		56.00
56.01 03630 ULTRASOUND	11,140,680	0	0	0		56.01
57.00 05700 CT SCAN	48,017,072	0	0	0		57.00
58.00 05800 MRI	13,234,965	0	0	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	14,732,028	0	0	0		59.00
60.00 06000 LABORATORY	85,794,225	0	0	0		60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0		62.30
65.00 06500 RESPIRATORY THERAPY	11,565,744	0	0	0		65.00
66.00 06600 PHYSICAL THERAPY	23,911,930	0	0	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	5,184,382	0	0	0		67.00
68.00 06800 SPEECH PATHOLOGY	2,108,929	0	0	0		68.00
69.00 06900 ELECTROCARDIOLOGY	17,292,431	0	0	0		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	2,075,005	0	0	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	9,854,629	0	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	15,404,118	0	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	23,561,208	0	0	0		73.00
73.01 07301 OUTPATIENT PHARMACY	0	0	0	0		73.01
74.00 07400 RENAL DIALYSIS	678,757	0	0	0		74.00
76.00 03950 LI THOTRI PSY	0	0	0	0		76.00
76.01 03951 CARDIAC REHABILITATION	1,054,703	0	0	0		76.01
76.02 03020 GASTROINTESTINAL SERVICES	11,348,313	0	0	0		76.02
76.03 03030 ANGIOCARDIOGRAPHY	0	0	0	0		76.03
76.05 03954 INPATIENT RENAL DIALYSIS	0	0	0	0		76.05
76.97 07697 CARDIAC REHABILITATION	0	0	0	0		76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0	0	0		76.98
76.99 07699 LI THOTRI PSY	0	0	0	0		76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000 CLINIC	13,790	0	0	0		90.00
90.01 09001 OUTPATIENT INFUSION PROCEDURES	0	0	0	0		90.01
90.02 04950 WOUND CARE	3,311,331	0	0	0		90.02
90.03 09003 RIVER FOREST	0	0	0	0		90.03
91.00 09100 EMERGENCY	51,274,861	0	0	0	99	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0008

Period:  
From 07/01/2016  
To 06/30/2017

Worksheet B-1

Date/Time Prepared:  
11/30/2017 8:36 am

Cost Center Description	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	SOCIAL SERVICE (TOTAL PATIENT DAYS)	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	NURSING SCHOOL (ASSIGNED TIME)	INTERNS & RESIDENTS	
	16.00	17.00	19.00	20.00	SERVICES-SALARY & FRINGES APPRV ((ASSIGNED TIME))	
<b>OTHER REIMBURSABLE COST CENTERS</b>						
99.10 09910 CORF	0	0	0	0	0	99.10
99.20 09920 OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99.20
99.30 09930 OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40 09940 OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
<b>SPECIAL PURPOSE COST CENTERS</b>						
118.00	SUBTOTALS (SUM OF LINES 1-117)	546,559,071	43,534	0	0	100 118.00
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
192.01 19201 NON-EMPLOYEE CHILD CARE CENTER	0	0	0	0	0	192.01
192.02 19202 OUTPATIENT PHARMACY	0	0	0	0	0	192.02
192.03 19203 WEST TOWN PHO	0	0	0	0	0	192.03
193.00 19300 NONPAID WORKERS	0	0	0	0	0	193.00
193.01 19301 ADULT DAY CARE	0	0	0	0	0	193.01
194.00 07950 DISCONTINUED HOME HEALTH AND HOSPICE	0	0	0	0	0	194.00
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	2,219,424	1,763,451	0	0	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	0.004061	40.507442	0.000000	0.000000	0.000000 203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	65,458	10,515	0	0	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000120	0.241535	0.000000	0.000000	0.000000 205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0008

Period:  
From 07/01/2016  
To 06/30/2017

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Cost Center Description	INTERNS & RESIDENTS	PARAMED PRGM (ASSIGNED TIME)	
	SERVICER-OTHER PRGM COSTS APPRV ((ASSIGNED TIME))		
	22.00		
<b>GENERAL SERVICE COST CENTERS</b>			
1.00 00100 CAP REL COSTS-BLDG & FIXT			1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP			2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00 00500 ADMINISTRATIVE & GENERAL			5.00
6.00 00600 MAINTENANCE & REPAIRS			6.00
7.00 00700 OPERATION OF PLANT			7.00
8.00 00800 LAUNDRY & LINEN SERVICE			8.00
9.00 00900 HOUSEKEEPING			9.00
10.00 01000 DIETARY			10.00
11.00 01100 CAFETERIA			11.00
12.00 01200 MAINTENANCE OF PERSONNEL			12.00
13.00 01300 NURSING ADMINISTRATION			13.00
14.00 01400 CENTRAL SERVICES & SUPPLY			14.00
15.00 01500 PHARMACY			15.00
16.00 01600 MEDICAL RECORDS & LIBRARY			16.00
17.00 01700 SOCIAL SERVICE			17.00
19.00 01900 NONPHYSICIAN ANESTHETISTS			19.00
20.00 02000 NURSING SCHOOL			20.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV	100		21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV			22.00
23.00 02300 PARAMED PRGM-(SPECIFY)		0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>			
30.00 03000 ADULTS & PEDIATRICS	1	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0	31.00
40.00 04000 SUBPROVIDER - IPF	0	0	40.00
41.00 04100 SUBPROVIDER - IRF	0	0	41.00
43.00 04300 NURSERY	0	0	43.00
44.00 04400 SKILLED NURSING FACILITY	0	0	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>			
50.00 05000 OPERATING ROOM	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
56.00 05600 RADIO SOTOPE	0	0	56.00
56.01 03630 ULTRASOUND	0	0	56.01
57.00 05700 CT SCAN	0	0	57.00
58.00 05800 MRI	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00 06000 LABORATORY	0	0	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	62.30
65.00 06500 RESPIRATORY THERAPY	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
73.01 07301 OUTPATIENT PHARMACY	0	0	73.01
74.00 07400 RENAL DIALYSIS	0	0	74.00
76.00 03950 LI THOTRI PSY	0	0	76.00
76.01 03951 CARDIAC REHABILITATION	0	0	76.01
76.02 03020 GASTROINTESTINAL SERVICES	0	0	76.02
76.03 03030 ANGIOCARDIOGRAPHY	0	0	76.03
76.05 03954 INPATIENT RENAL DIALYSIS	0	0	76.05
76.97 07697 CARDIAC REHABILITATION	0	0	76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0	76.98
76.99 07699 LI THOTRI PSY	0	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>			
90.00 09000 CLINIC	0	0	90.00
90.01 09001 OUTPATIENT INFUSION PROCEDURES	0	0	90.01
90.02 04950 WOUND CARE	0	0	90.02
90.03 09003 RIVER FOREST	0	0	90.03
91.00 09100 EMERGENCY	99	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART			92.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 14-0008

Period:  
From 07/01/2016  
To 06/30/2017

Worksheet B-1

Date/Time Prepared:  
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Cost Center Description	INTERNS & RESIDENTS	PARAMETERED PRGM (ASSIGNED TIME)	
	SERVICES-OTHER PRGM COSTS APPRV ((ASSIGNED TIME))		
	22.00		
<b>OTHER REIMBURSABLE COST CENTERS</b>			
99.10 09910 CORF	0	0	99.10
99.20 09920 OUTPATIENT PHYSICAL THERAPY	0	0	99.20
99.30 09930 OUTPATIENT OCCUPATIONAL THERAPY	0	0	99.30
99.40 09940 OUTPATIENT SPEECH PATHOLOGY	0	0	99.40
<b>SPECIAL PURPOSE COST CENTERS</b>			
118.00	SUBTOTALS (SUM OF LINES 1-117)	100	0
<b>NONREIMBURSABLE COST CENTERS</b>			
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	192.00
192.01 19201 NON-EMPLOYEE CHILD CARE CENTER	0	0	192.01
192.02 19202 OUTPATIENT PHARMACY	0	0	192.02
192.03 19203 WEST TOWN PHO	0	0	192.03
193.00 19300 NONPAID WORKERS	0	0	193.00
193.01 19301 ADULT DAY CARE	0	0	193.01
194.00 07950 DISCONTINUED HOME HEALTH AND HOSPICE	0	0	194.00
200.00	Cross Foot Adjustments		200.00
201.00	Negative Cost Centers		201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	431,089	0
203.00	Unit cost multiplier (Wkst. B, Part I)	4,310.890000	0.000000
204.00	Cost to be allocated (per Wkst. B, Part II)	1,282	0
205.00	Unit cost multiplier (Wkst. B, Part II)	12.820000	0.000000

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 14-0008		Period: From 07/01/2016 To 06/30/2017		Worksheet C Part I Date/Time Prepared: 11/30/2017 8:36 am		
		Title XVIII		Hospital		PPS		
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
				Total Costs	RCE Disallowance	Total Costs		
		1.00	2.00	3.00	4.00	5.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	23,956,983		23,956,983	0	23,956,983	30.00
31.00	03100	INTENSIVE CARE UNIT	5,484,954		5,484,954	0	5,484,954	31.00
40.00	04000	SUBPROVIDER - IPF	2,156,140		2,156,140	0	2,156,140	40.00
41.00	04100	SUBPROVIDER - IRF	5,503,359		5,503,359	0	5,503,359	41.00
43.00	04300	NURSERY	493,565		493,565	0	493,565	43.00
44.00	04400	SKILLED NURSING FACILITY	6,484,053		6,484,053	0	6,484,053	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	9,350,812		9,350,812	0	9,350,812	50.00
51.00	05100	RECOVERY ROOM	914,543		914,543	0	914,543	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,468,451		1,468,451	0	1,468,451	52.00
53.00	05300	ANESTHESIOLOGY	177,378		177,378	0	177,378	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,257,329		3,257,329	0	3,257,329	54.00
56.00	05600	RADIOISOTOPE	450,188		450,188	0	450,188	56.00
56.01	03630	ULTRASOUND	951,827		951,827	0	951,827	56.01
57.00	05700	CT SCAN	989,476		989,476	0	989,476	57.00
58.00	05800	MRI	660,315		660,315	0	660,315	58.00
59.00	05900	CARDIAC CATHETERIZATION	1,084,966		1,084,966	0	1,084,966	59.00
60.00	06000	LABORATORY	8,281,995		8,281,995	0	8,281,995	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	1,759,323	0	1,759,323	0	1,759,323	65.00
66.00	06600	PHYSICAL THERAPY	4,911,814	0	4,911,814	0	4,911,814	66.00
67.00	06700	OCCUPATIONAL THERAPY	527,386	0	527,386	0	527,386	67.00
68.00	06800	SPEECH PATHOLOGY	395,575	0	395,575	0	395,575	68.00
69.00	06900	ELECTROCARDIOLOGY	895,584		895,584	0	895,584	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	229,725		229,725	0	229,725	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	9,875,618		9,875,618	0	9,875,618	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	8,543,939		8,543,939	0	8,543,939	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	6,145,283		6,145,283	0	6,145,283	73.00
73.01	07301	OUTPATIENT PHARMACY	0		0	0	0	73.01
74.00	07400	RENAL DIALYSIS	616,478		616,478	0	616,478	74.00
76.00	03950	LI THOTRI PSY	0		0	0	0	76.00
76.01	03951	CARDIAC REHABILITATION	635,491		635,491	0	635,491	76.01
76.02	03020	GASTROINTESTINAL SERVICES	1,577,729		1,577,729	0	1,577,729	76.02
76.03	03030	ANGIOCARDIOGRAPHY	0		0	0	0	76.03
76.05	03954	INPATIENT RENAL DIALYSIS	0		0	0	0	76.05
76.97	07697	CARDIAC REHABILITATION	0		0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98
76.99	07699	LI THOTRI PSY	0		0	0	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	7,009		7,009	0	7,009	90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES	0		0	0	0	90.01
90.02	04950	WOUND CARE	1,166,223		1,166,223	0	1,166,223	90.02
90.03	09003	RIVER FOREST	0		0	0	0	90.03
91.00	09100	EMERGENCY	6,322,859		6,322,859	0	6,322,859	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	2,344,570		2,344,570	0	2,344,570	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
99.10	09910	CORF	0		0	0	0	99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0		0	0	0	99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0		0	0	0	99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0		0	0	0	99.40
200.00		Subtotal (see instructions)	117,620,940	0	117,620,940	0	117,620,940	200.00
201.00		Less Observation Beds	2,344,570		2,344,570	0	2,344,570	201.00
202.00		Total (see instructions)	115,276,370	0	115,276,370	0	115,276,370	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0008		Period: From 07/01/2016 To 06/30/2017		Worksheet C Part I Date/Time Prepared: 11/30/2017 8:36 am		
			Title XVIII			Hospital		PPS	
Cost Center Description			Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
			Inpatient	Outpatient	Total (col. 6 + col. 7)				
			6.00	7.00	8.00	9.00	10.00		
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	62,325,098		62,325,098				30.00
31.00	03100	INTENSIVE CARE UNIT	14,171,593		14,171,593				31.00
40.00	04000	SUBPROVIDER - IPF	6,730,992		6,730,992				40.00
41.00	04100	SUBPROVIDER - IRF	6,982,303		6,982,303				41.00
43.00	04300	NURSERY	1,010,332		1,010,332				43.00
44.00	04400	SKILLED NURSING FACILITY	8,242,107		8,242,107				44.00
ANCILLARY SERVICE COST CENTERS									
50.00	05000	OPERATING ROOM	10,659,390	14,922,596	25,581,986	0.365523	0.000000		50.00
51.00	05100	RECOVERY ROOM	4,878,601	6,307,264	11,185,865	0.081759	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,068,910	113,778	2,182,688	0.672772	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	9,140,486	11,448,164	20,588,650	0.008615	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,236,467	14,911,950	20,148,417	0.161667	0.000000		54.00
56.00	05600	RADIOISOTOPE	1,949,337	4,715,600	6,664,937	0.067546	0.000000		56.00
56.01	03630	ULTRASOUND	2,790,108	8,350,572	11,140,680	0.085437	0.000000		56.01
57.00	05700	CT SCAN	14,420,991	33,596,081	48,017,072	0.020607	0.000000		57.00
58.00	05800	MRI	2,838,001	10,396,964	13,234,965	0.049892	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	9,444,988	5,287,040	14,732,028	0.073647	0.000000		59.00
60.00	06000	LABORATORY	33,173,132	52,621,093	85,794,225	0.096533	0.000000		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000		62.30
65.00	06500	RESPIRATORY THERAPY	10,739,276	826,468	11,565,744	0.152115	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	19,027,351	4,884,579	23,911,930	0.205413	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	4,537,872	646,510	5,184,382	0.101726	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	1,451,226	657,703	2,108,929	0.187572	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	8,412,747	8,879,684	17,292,431	0.051791	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	347,512	1,727,493	2,075,005	0.110711	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,793,282	4,061,347	9,854,629	1.002130	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,132,244	4,271,874	15,404,118	0.554653	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	16,391,093	7,170,115	23,561,208	0.260822	0.000000		73.00
73.01	07301	OUTPATIENT PHARMACY	0	0	0	0.000000	0.000000		73.01
74.00	07400	RENAL DIALYSIS	662,216	16,541	678,757	0.908246	0.000000		74.00
76.00	03950	LITHOTRIpsy	0	0	0	0.000000	0.000000		76.00
76.01	03951	CARDIAC REHABILITATION	826	1,053,877	1,054,703	0.602531	0.000000		76.01
76.02	03020	GASTROINTESTINAL SERVICES	2,464,872	8,883,441	11,348,313	0.139028	0.000000		76.02
76.03	03030	ANGIOCARDIOGRAPHY	0	0	0	0.000000	0.000000		76.03
76.05	03954	INPATIENT RENAL DIALYSIS	0	0	0	0.000000	0.000000		76.05
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	0.000000		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	0.000000		76.98
76.99	07699	LITHOTRIpsy	0	0	0	0.000000	0.000000		76.99
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	13,790	13,790	0.508267	0.000000		90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES	0	0	0	0.000000	0.000000		90.01
90.02	04950	WOUND CARE	6,123	3,305,208	3,311,331	0.352192	0.000000		90.02
90.03	09003	RIVER FOREST	0	0	0	0.000000	0.000000		90.03
91.00	09100	EMERGENCY	14,066,506	37,208,355	51,274,861	0.123313	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3,035,492	6,149,510	9,185,002	0.255261	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS									
99.10	09910	CORF	0	0	0				99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0				99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0				99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0				99.40
200.00		Subtotal (see instructions)	294,131,474	252,427,597	546,559,071				200.00
201.00		Less Observation Beds							201.00
202.00		Total (see instructions)	294,131,474	252,427,597	546,559,071				202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0008	Period: From 07/01/2016 To 06/30/2017	Worksheet C Part I Date/Time Prepared: 11/30/2017 8:36 am
Cost Center Description			PPS Inpatient Ratio	Title XVIII	Hospital
			11.00		PPS
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
41.00	04100	SUBPROVIDER - IRF			41.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.365523		50.00
51.00	05100	RECOVERY ROOM	0.081759		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.672772		52.00
53.00	05300	ANESTHESIOLOGY	0.008615		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.161667		54.00
56.00	05600	RADIOISOTOPE	0.067546		56.00
56.01	03630	ULTRASOUND	0.085437		56.01
57.00	05700	CT SCAN	0.020607		57.00
58.00	05800	MRI	0.049892		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.073647		59.00
60.00	06000	LABORATORY	0.096533		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000		62.30
65.00	06500	RESPIRATORY THERAPY	0.152115		65.00
66.00	06600	PHYSICAL THERAPY	0.205413		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.101726		67.00
68.00	06800	SPEECH PATHOLOGY	0.187572		68.00
69.00	06900	ELECTROCARDIOLOGY	0.051791		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.110711		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.002130		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.554653		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.260822		73.00
73.01	07301	OUTPATIENT PHARMACY	0.000000		73.01
74.00	07400	RENAL DIALYSIS	0.908246		74.00
76.00	03950	LI THOTRI PSY	0.000000		76.00
76.01	03951	CARDIAC REHABILITATION	0.602531		76.01
76.02	03020	GASTROINTESTINAL SERVICES	0.139028		76.02
76.03	03030	ANGIOCARDIOGRAPHY	0.000000		76.03
76.05	03954	INPATIENT RENAL DIALYSIS	0.000000		76.05
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000		76.98
76.99	07699	LI THOTRI PSY	0.000000		76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	0.508267		90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES	0.000000		90.01
90.02	04950	WOUND CARE	0.352192		90.02
90.03	09003	RIVER FOREST	0.000000		90.03
91.00	09100	EMERGENCY	0.123313		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.255261		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
99.10	09910	CORF			99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY			99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY			99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY			99.40
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0008

Period:  
From 07/01/2016  
To 06/30/2017

Worksheet C  
Part I  
Date/Time Prepared:  
11/30/2017 8:36 am

		Title XIX		Hospital		Cost	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
			Total Costs	RCE Disallowance	Total Costs		
	1.00	2.00	3.00	4.00	5.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS	23,956,983		23,956,983	0	23,956,983	30.00
31.00	03100 INTENSIVE CARE UNIT	5,484,954		5,484,954	0	5,484,954	31.00
40.00	04000 SUBPROVIDER - IPF	2,156,140		2,156,140	0	2,156,140	40.00
41.00	04100 SUBPROVIDER - IRF	5,503,359		5,503,359	0	5,503,359	41.00
43.00	04300 NURSERY	493,565		493,565	0	493,565	43.00
44.00	04400 SKILLED NURSING FACILITY	6,484,053		6,484,053	0	6,484,053	44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	9,350,812		9,350,812	0	9,350,812	50.00
51.00	05100 RECOVERY ROOM	914,543		914,543	0	914,543	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1,468,451		1,468,451	0	1,468,451	52.00
53.00	05300 ANESTHESIOLOGY	177,378		177,378	0	177,378	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	3,257,329		3,257,329	0	3,257,329	54.00
56.00	05600 RADIOISOTOPE	450,188		450,188	0	450,188	56.00
56.01	03630 ULTRASOUND	951,827		951,827	0	951,827	56.01
57.00	05700 CT SCAN	989,476		989,476	0	989,476	57.00
58.00	05800 MRI	660,315		660,315	0	660,315	58.00
59.00	05900 CARDIAC CATHETERIZATION	1,084,966		1,084,966	0	1,084,966	59.00
60.00	06000 LABORATORY	8,281,995		8,281,995	0	8,281,995	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	1,759,323	0	1,759,323	0	1,759,323	65.00
66.00	06600 PHYSICAL THERAPY	4,911,814	0	4,911,814	0	4,911,814	66.00
67.00	06700 OCCUPATIONAL THERAPY	527,386	0	527,386	0	527,386	67.00
68.00	06800 SPEECH PATHOLOGY	395,575	0	395,575	0	395,575	68.00
69.00	06900 ELECTROCARDIOLOGY	895,584		895,584	0	895,584	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	229,725		229,725	0	229,725	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	9,875,618		9,875,618	0	9,875,618	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	8,543,939		8,543,939	0	8,543,939	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	6,145,283		6,145,283	0	6,145,283	73.00
73.01	07301 OUTPATIENT PHARMACY	0		0	0	0	73.01
74.00	07400 RENAL DIALYSIS	616,478		616,478	0	616,478	74.00
76.00	03950 LI THOTRI PSY	0		0	0	0	76.00
76.01	03951 CARDIAC REHABILITATION	635,491		635,491	0	635,491	76.01
76.02	03020 GASTROINTESTINAL SERVICES	1,577,729		1,577,729	0	1,577,729	76.02
76.03	03030 ANGIOCARDIOGRAPHY	0		0	0	0	76.03
76.05	03954 INPATIENT RENAL DIALYSIS	0		0	0	0	76.05
76.97	07697 CARDIAC REHABILITATION	0		0	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0		0	0	0	76.98
76.99	07699 LI THOTRI PSY	0		0	0	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	7,009		7,009	0	7,009	90.00
90.01	09001 OUTPATIENT INFUSION PROCEDURES	0		0	0	0	90.01
90.02	04950 WOUND CARE	1,166,223		1,166,223	0	1,166,223	90.02
90.03	09003 RIVER FOREST	0		0	0	0	90.03
91.00	09100 EMERGENCY	6,322,859		6,322,859	0	6,322,859	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	2,344,570		2,344,570	0	2,344,570	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	09910 CORF	0		0	0	0	99.10
99.20	09920 OUTPATIENT PHYSICAL THERAPY	0		0	0	0	99.20
99.30	09930 OUTPATIENT OCCUPATIONAL THERAPY	0		0	0	0	99.30
99.40	09940 OUTPATIENT SPEECH PATHOLOGY	0		0	0	0	99.40
200.00	Subtotal (see instructions)	117,620,940	0	117,620,940	0	117,620,940	200.00
201.00	Less Observation Beds	2,344,570		2,344,570	0	2,344,570	201.00
202.00	Total (see instructions)	115,276,370	0	115,276,370	0	115,276,370	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 14-0008

Period:  
From 07/01/2016  
To 06/30/2017

Worksheet C  
Part I  
Date/Time Prepared:  
11/30/2017 8:36 am

		Title XIX			Hospital	Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	62,325,098		62,325,098		30.00
31.00	03100	INTENSIVE CARE UNIT	14,171,593		14,171,593		31.00
40.00	04000	SUBPROVIDER - IPF	6,730,992		6,730,992		40.00
41.00	04100	SUBPROVIDER - IRF	6,982,303		6,982,303		41.00
43.00	04300	NURSERY	1,010,332		1,010,332		43.00
44.00	04400	SKILLED NURSING FACILITY	8,242,107		8,242,107		44.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	10,659,390	14,922,596	25,581,986	0.365523	50.00
51.00	05100	RECOVERY ROOM	4,878,601	6,307,264	11,185,865	0.081759	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	2,068,910	113,778	2,182,688	0.672772	52.00
53.00	05300	ANESTHESIOLOGY	9,140,486	11,448,164	20,588,650	0.008615	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,236,467	14,911,950	20,148,417	0.161667	54.00
56.00	05600	RADIOISOTOPE	1,949,337	4,715,600	6,664,937	0.067546	56.00
56.01	03630	ULTRASOUND	2,790,108	8,350,572	11,140,680	0.085437	56.01
57.00	05700	CT SCAN	14,420,991	33,596,081	48,017,072	0.020607	57.00
58.00	05800	MRI	2,838,001	10,396,964	13,234,965	0.049892	58.00
59.00	05900	CARDIAC CATHETERIZATION	9,444,988	5,287,040	14,732,028	0.073647	59.00
60.00	06000	LABORATORY	33,173,132	52,621,093	85,794,225	0.096533	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	62.30
65.00	06500	RESPIRATORY THERAPY	10,739,276	826,468	11,565,744	0.152115	65.00
66.00	06600	PHYSICAL THERAPY	19,027,351	4,884,579	23,911,930	0.205413	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,537,872	646,510	5,184,382	0.101726	67.00
68.00	06800	SPEECH PATHOLOGY	1,451,226	657,703	2,108,929	0.187572	68.00
69.00	06900	ELECTROCARDIOLOGY	8,412,747	8,879,684	17,292,431	0.051791	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	347,512	1,727,493	2,075,005	0.110711	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	5,793,282	4,061,347	9,854,629	1.002130	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	11,132,244	4,271,874	15,404,118	0.554653	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	16,391,093	7,170,115	23,561,208	0.260822	73.00
73.01	07301	OUTPATIENT PHARMACY	0	0	0	0.000000	73.01
74.00	07400	RENAL DIALYSIS	662,216	16,541	678,757	0.908246	74.00
76.00	03950	LITHOTRIpsy	0	0	0	0.000000	76.00
76.01	03951	CARDIAC REHABILITATION	826	1,053,877	1,054,703	0.602531	76.01
76.02	03020	GASTROINTESTINAL SERVICES	2,464,872	8,883,441	11,348,313	0.139028	76.02
76.03	03030	ANGIOCARDIOGRAPHY	0	0	0	0.000000	76.03
76.05	03954	INPATIENT RENAL DIALYSIS	0	0	0	0.000000	76.05
76.97	07697	CARDIAC REHABILITATION	0	0	0	0.000000	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0.000000	76.98
76.99	07699	LITHOTRIpsy	0	0	0	0.000000	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000	CLINIC	0	13,790	13,790	0.508267	90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES	0	0	0	0.000000	90.01
90.02	04950	WOUND CARE	6,123	3,305,208	3,311,331	0.352192	90.02
90.03	09003	RIVER FOREST	0	0	0	0.000000	90.03
91.00	09100	EMERGENCY	14,066,506	37,208,355	51,274,861	0.123313	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3,035,492	6,149,510	9,185,002	0.255261	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
99.10	09910	CORF	0	0	0		99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0		99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0		99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0		99.40
200.00		Subtotal (see instructions)	294,131,474	252,427,597	546,559,071		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	294,131,474	252,427,597	546,559,071		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 14-0008	Period: From 07/01/2016 To 06/30/2017	Worksheet C Part I Date/Time Prepared: 11/30/2017 8:36 am
Cost Center Description			PPS Inpatient Ratio	Title XIX	Hospital Cost
			11.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
41.00	04100	SUBPROVIDER - IRF			41.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.000000		50.00
51.00	05100	RECOVERY ROOM	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000		54.00
56.00	05600	RADIOISOTOPE	0.000000		56.00
56.01	03630	ULTRASOUND	0.000000		56.01
57.00	05700	CT SCAN	0.000000		57.00
58.00	05800	MRI	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.000000		60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000		62.30
65.00	06500	RESPIRATORY THERAPY	0.000000		65.00
66.00	06600	PHYSICAL THERAPY	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000		73.00
73.01	07301	OUTPATIENT PHARMACY	0.000000		73.01
74.00	07400	RENAL DIALYSIS	0.000000		74.00
76.00	03950	LI THOTRI PSY	0.000000		76.00
76.01	03951	CARDIAC REHABILITATION	0.000000		76.01
76.02	03020	GASTROINTESTINAL SERVICES	0.000000		76.02
76.03	03030	ANGIOCARDIOGRAPHY	0.000000		76.03
76.05	03954	INPATIENT RENAL DIALYSIS	0.000000		76.05
76.97	07697	CARDIAC REHABILITATION	0.000000		76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000		76.98
76.99	07699	LI THOTRI PSY	0.000000		76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	0.000000		90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES	0.000000		90.01
90.02	04950	WOUND CARE	0.000000		90.02
90.03	09003	RIVER FOREST	0.000000		90.03
91.00	09100	EMERGENCY	0.000000		91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
99.10	09910	CORF			99.10
99.20	09920	OUTPATIENT PHYSICAL THERAPY			99.20
99.30	09930	OUTPATIENT OCCUPATIONAL THERAPY			99.30
99.40	09940	OUTPATIENT SPEECH PATHOLOGY			99.40
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS	Provider CCN: 14-0008	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part I Date/Time Prepared: 11/30/2017 8:36 am
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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	4,964,351	0	4,964,351	23,941	207.36	30.00	
31.00	INTENSIVE CARE UNIT	247,212		247,212	3,786	65.30	31.00	
40.00	SUBPROVIDER - IPF	114,651	0	114,651	2,839	40.38	40.00	
41.00	SUBPROVIDER - IRF	1,276,435	0	1,276,435	5,777	220.95	41.00	
43.00	NURSERY	28,351		28,351	527	53.80	43.00	
44.00	SKILLED NURSING FACILITY	284,313		284,313	9,007	31.57	44.00	
200.00	Total (lines 30-199)	6,915,313		6,915,313	45,877		200.00	
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)					
		6.00	7.00					
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	ADULTS & PEDIATRICS	9,942	2,061,573					30.00
31.00	INTENSIVE CARE UNIT	1,799	117,475					31.00
40.00	SUBPROVIDER - IPF	2,758	111,368					40.00
41.00	SUBPROVIDER - IRF	2,797	617,997					41.00
43.00	NURSERY	0	0					43.00
44.00	SKILLED NURSING FACILITY	6,360	200,785					44.00
200.00	Total (lines 30-199)	23,656	3,109,198					200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 14-0008	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part II Date/Time Prepared: 11/30/2017 8:36 am
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Title XVIII		Hospital	PPS	
			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	650,741	25,581,986	0.025437	3,894,957	99,076	50.00
51.00	05100 RECOVERY ROOM	34,175	11,185,865	0.003055	1,730,650	5,287	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	135,059	2,182,688	0.061877	4,233	262	52.00
53.00	05300 ANESTHESIOLOGY	14,242	20,588,650	0.000692	3,240,070	2,242	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	203,103	20,148,417	0.010080	2,376,676	23,957	54.00
56.00	05600 RADIOISOTOPE	37,437	6,664,937	0.005617	965,689	5,424	56.00
56.01	03630 ULTRASOUND	41,189	11,140,680	0.003697	1,191,402	4,405	56.01
57.00	05700 CT SCAN	32,618	48,017,072	0.000679	6,208,958	4,216	57.00
58.00	05800 MRI	46,987	13,234,965	0.003550	1,146,793	4,071	58.00
59.00	05900 CARDIAC CATHETERIZATION	44,954	14,732,028	0.003051	2,895,716	8,835	59.00
60.00	06000 LABORATORY	240,103	85,794,225	0.002799	13,637,182	38,170	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	32,309	11,565,744	0.002794	4,160,728	11,625	65.00
66.00	06600 PHYSICAL THERAPY	410,247	23,911,930	0.017157	1,503,761	25,800	66.00
67.00	06700 OCCUPATIONAL THERAPY	33,389	5,184,382	0.006440	573,909	3,696	67.00
68.00	06800 SPEECH PATHOLOGY	20,307	2,108,929	0.009629	157,647	1,518	68.00
69.00	06900 ELECTROCARDIOLOGY	44,215	17,292,431	0.002557	4,197,063	10,732	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	20,405	2,075,005	0.009834	158,416	1,558	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	95,456	9,854,629	0.009686	2,265,795	21,946	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	83,140	15,404,118	0.005397	4,861,719	26,239	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	72,335	23,561,208	0.003070	6,084,222	18,679	73.00
73.01	07301 OUTPATIENT PHARMACY	0	0	0.000000	0	0	73.01
74.00	07400 RENAL DIALYSIS	1,869	678,757	0.002754	202,494	558	74.00
76.00	03950 LI THOTRI PSY	0	0	0.000000	0	0	76.00
76.01	03951 CARDIAC REHABILITATION	68,792	1,054,703	0.065224	580	38	76.01
76.02	03020 GASTROINTESTINAL SERVICES	81,284	11,348,313	0.007163	1,063,259	7,616	76.02
76.03	03030 ANGIOCARDIOGRAPHY	0	0	0.000000	0	0	76.03
76.05	03954 INPATIENT RENAL DIALYSIS	0	0	0.000000	0	0	76.05
76.97	07697 CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699 LI THOTRI PSY	0	0	0.000000	0	0	76.99
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	1,693	13,790	0.122770	0	0	90.00
90.01	09001 OUTPATIENT INFUSION PROCEDURES	0	0	0.000000	0	0	90.01
90.02	04950 WOUND CARE	47,256	3,311,331	0.014271	3,941	56	90.02
90.03	09003 RIVER FOREST	0	0	0.000000	0	0	90.03
91.00	09100 EMERGENCY	249,927	51,274,861	0.004874	5,913,894	28,824	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	485,839	9,185,002	0.052895	1,314,130	69,511	92.00
200.00	Total (lines 50-199)	3,229,071	447,096,646		69,753,884	424,341	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0008	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part III Date/Time Prepared: 11/30/2017 8:36 am
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Cost Center Description	Title XVIII				Hospital		PPS
	Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)		
	1.00	2.00	3.00	4.00	5.00		

INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00

Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
	6.00	7.00	8.00	9.00	

INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	23,941	0.00	9,942	0	30.00
31.00	03100	INTENSIVE CARE UNIT	3,786	0.00	1,799	0	31.00
40.00	04000	SUBPROVIDER - IPF	2,839	0.00	2,758	0	40.00
41.00	04100	SUBPROVIDER - IRF	5,777	0.00	2,797	0	41.00
43.00	04300	NURSERY	527	0.00	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	9,007	0.00	6,360	0	44.00
200.00		Total (lines 30-199)	45,877		23,656	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0008

Period:  
From 07/01/2016  
To 06/30/2017

Worksheet D  
Part IV  
Date/Time Prepared:  
11/30/2017 8:36 am

Cost Center Description		Title XVIII			Hospital		PPS	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)		
		1.00	2.00	3.00	4.00	5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	0	56.00
56.01	03630	ULTRASOUND	0	0	0	0	0	56.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	OUTPATIENT PHARMACY	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	LI THOTRI PSY	0	0	0	0	0	76.00
76.01	03951	CARDIAC REHABILITATION	0	0	0	0	0	76.01
76.02	03020	GASTROINTESTINAL SERVICES	0	0	0	0	0	76.02
76.03	03030	ANGIOCARDIOGRAPHY	0	0	0	0	0	76.03
76.05	03954	INPATIENT RENAL DIALYSIS	0	0	0	0	0	76.05
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LI THOTRI PSY	0	0	0	0	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES	0	0	0	0	0	90.01
90.02	04950	WOUND CARE	0	0	0	0	0	90.02
90.03	09003	RIVER FOREST	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (Lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0008	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part IV Date/Time Prepared: 11/30/2017 8:36 am
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Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Hospital		Inpatient Program Charges	
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	PPS		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	25,581,986	0.000000	0.000000	3,894,957	50.00
51.00	05100	RECOVERY ROOM	0	11,185,865	0.000000	0.000000	1,730,650	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,182,688	0.000000	0.000000	4,233	52.00
53.00	05300	ANESTHESIOLOGY	0	20,588,650	0.000000	0.000000	3,240,070	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	20,148,417	0.000000	0.000000	2,376,676	54.00
56.00	05600	RADIOISOTOPE	0	6,664,937	0.000000	0.000000	965,689	56.00
56.01	03630	ULTRASOUND	0	11,140,680	0.000000	0.000000	1,191,402	56.01
57.00	05700	CT SCAN	0	48,017,072	0.000000	0.000000	6,208,958	57.00
58.00	05800	MRI	0	13,234,965	0.000000	0.000000	1,146,793	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	14,732,028	0.000000	0.000000	2,895,716	59.00
60.00	06000	LABORATORY	0	85,794,225	0.000000	0.000000	13,637,182	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0.000000	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	11,565,744	0.000000	0.000000	4,160,728	65.00
66.00	06600	PHYSICAL THERAPY	0	23,911,930	0.000000	0.000000	1,503,761	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	5,184,382	0.000000	0.000000	573,909	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,108,929	0.000000	0.000000	157,647	68.00
69.00	06900	ELECTROCARDIOLOGY	0	17,292,431	0.000000	0.000000	4,197,063	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2,075,005	0.000000	0.000000	158,416	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	9,854,629	0.000000	0.000000	2,265,795	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	15,404,118	0.000000	0.000000	4,861,719	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	23,561,208	0.000000	0.000000	6,084,222	73.00
73.01	07301	OUTPATIENT PHARMACY	0	0	0.000000	0.000000	0	73.01
74.00	07400	RENAL DIALYSIS	0	678,757	0.000000	0.000000	202,494	74.00
76.00	03950	LI THOTRI PSY	0	0	0.000000	0.000000	0	76.00
76.01	03951	CARDIAC REHABILITATION	0	1,054,703	0.000000	0.000000	580	76.01
76.02	03020	GASTROINTESTINAL SERVICES	0	11,348,313	0.000000	0.000000	1,063,259	76.02
76.03	03030	ANGIOCARDIOGRAPHY	0	0	0.000000	0.000000	0	76.03
76.05	03954	INPATIENT RENAL DIALYSIS	0	0	0.000000	0.000000	0	76.05
76.97	07697	CARDIAC REHABILITATION	0	0	0.000000	0.000000	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0.000000	0	76.98
76.99	07699	LI THOTRI PSY	0	0	0.000000	0.000000	0	76.99
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	13,790	0.000000	0.000000	0	90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES	0	0	0.000000	0.000000	0	90.01
90.02	04950	WOUND CARE	0	3,311,331	0.000000	0.000000	3,941	90.02
90.03	09003	RIVER FOREST	0	0	0.000000	0.000000	0	90.03
91.00	09100	EMERGENCY	0	51,274,861	0.000000	0.000000	5,913,894	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	9,185,002	0.000000	0.000000	1,314,130	92.00
200.00		Total (lines 50-199)	0	447,096,646			69,753,884	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0008	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part IV Date/Time Prepared: 11/30/2017 8:36 am
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Cost Center Description		Title XVIII						
		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges before Geo Recl assi fi cat ion	Outpatient Program Charges on/after Geo Recl assi fi cat ion	Outpatient Program Pass-Through Costs (col. 9 x col. 12) before Geo Recl assi fi cat ion	Outpatient Program Pass-Through Costs (col. 9 x col. 12) on/after Geo Recl assi fi cat ion		
		11.00	12.00	12.01	13.00	13.01		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	3,936,129	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	1,235,403	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	102	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	3,044,012	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	2,680,417	0	0	0	54.00
56.00	05600	RADIO SOTOPE	0	1,710,653	0	0	0	56.00
56.01	03630	ULTRASOUND	0	1,806,662	0	0	0	56.01
57.00	05700	CT SCAN	0	8,901,179	0	0	0	57.00
58.00	05800	MRI	0	3,305,572	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	2,671,714	0	0	0	59.00
60.00	06000	LABORATORY	0	4,169,166	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	310,576	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	63,312	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	17,092	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	110,930	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	2,859,648	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	422,080	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	1,065,956	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	1,623,574	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	2,166,297	0	0	0	73.00
73.01	07301	OUTPATIENT PHARMACY	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	14,616	0	0	0	74.00
76.00	03950	LI THOTRI PSY	0	0	0	0	0	76.00
76.01	03951	CARDIAC REHABILITATION	0	490,407	0	0	0	76.01
76.02	03020	GASTROINTESTINAL SERVICES	0	2,476,407	0	0	0	76.02
76.03	03030	ANGIOCARDIOGRAPHY	0	0	0	0	0	76.03
76.05	03954	INPATIENT RENAL DIALYSIS	0	0	0	0	0	76.05
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LI THOTRI PSY	0	0	0	0	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES	0	0	0	0	0	90.01
90.02	04950	WOUND CARE	0	1,207,260	0	0	0	90.02
90.03	09003	RIVER FOREST	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	6,020,645	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	1,566,078	0	0	0	92.00
200.00		Total (lines 50-199)	0	53,875,887	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-0008	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part V Date/Time Prepared: 11/30/2017 8:36 am
Title XVIII		Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges				
		PPS Reimbursed Services (see inst.) before Geographical Reclassification	PPS Reimbursed Services (see inst.) on/after Geographical Reclassification	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
		2.00	2.01	3.00	4.00	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	0.365523	3,936,129	0	0	0	50.00
51.00 05100 RECOVERY ROOM	0.081759	1,235,403	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.672772	102	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0.008615	3,044,012	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.161667	2,680,417	0	0	0	54.00
56.00 05600 RADIOISOTOPE	0.067546	1,710,653	0	0	0	56.00
56.01 03630 ULTRASOUND	0.085437	1,806,662	0	0	0	56.01
57.00 05700 CT SCAN	0.020607	8,901,179	0	0	0	57.00
58.00 05800 MRI	0.049892	3,305,572	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0.073647	2,671,714	0	0	0	59.00
60.00 06000 LABORATORY	0.096533	4,169,166	0	454	0	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00 06500 RESPIRATORY THERAPY	0.152115	310,576	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0.205413	63,312	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0.101726	17,092	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0.187572	110,930	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0.051791	2,859,648	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0.110711	422,080	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1.002130	1,065,956	0	16,986	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.554653	1,623,574	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.260822	2,166,297	0	0	25,477	73.00
73.01 07301 OUTPATIENT PHARMACY	0.000000	0	0	0	0	73.01
74.00 07400 RENAL DIALYSIS	0.908246	14,616	0	0	0	74.00
76.00 03950 LI THOTRI PSY	0.000000	0	0	0	0	76.00
76.01 03951 CARDIAC REHABILITATION	0.602531	490,407	0	0	0	76.01
76.02 03020 GASTROINTESTINAL SERVICES	0.139028	2,476,407	0	0	0	76.02
76.03 03030 ANGIOCARDIOGRAPHY	0.000000	0	0	0	0	76.03
76.05 03954 INPATIENT RENAL DIALYSIS	0.000000	0	0	0	0	76.05
76.97 07697 CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99 07699 LI THOTRI PSY	0.000000	0	0	0	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000 CLINIC	0.508267	0	0	0	0	90.00
90.01 09001 OUTPATIENT INFUSION PROCEDURES	0.000000	0	0	0	0	90.01
90.02 04950 WOUND CARE	0.352192	1,207,260	0	0	0	90.02
90.03 09003 RIVER FOREST	0.000000	0	0	0	0	90.03
91.00 09100 EMERGENCY	0.123313	6,020,645	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.255261	1,566,078	0	0	0	92.00
200.00 Subtotal (see instructions)		53,875,887	0	17,440	25,477	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges				0	0	201.00
202.00 Net Charges (line 200 +/- line 201)		53,875,887	0	17,440	25,477	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-0008	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part V Date/Time Prepared: 11/30/2017 8:36 am
Title XVIII		Hospital	PPS

Cost Center Description	Costs				5.00	5.01	6.00	7.00
	PPS Services (see inst.) before Geographical Reclassification	PPS Services (see inst.) on/after Geographical Reclassification	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)				
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	1,438,746	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	101,005	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	69	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	26,224	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	433,335	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	115,548	0	0	0	0	56.00
56.01	03630	ULTRASOUND	154,356	0	0	0	0	56.01
57.00	05700	CT SCAN	183,427	0	0	0	0	57.00
58.00	05800	MRI	164,922	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	196,764	0	0	0	0	59.00
60.00	06000	LABORATORY	402,462	0	44	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	47,243	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	13,005	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,739	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	20,807	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	148,104	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	46,729	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,068,226	0	17,022	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	900,520	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	565,018	0	0	0	6,645	73.00
73.01	07301	OUTPATIENT PHARMACY	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	13,275	0	0	0	0	74.00
76.00	03950	LI THOTRI PSY	0	0	0	0	0	76.00
76.01	03951	CARDIAC REHABILITATION	295,485	0	0	0	0	76.01
76.02	03020	GASTROINTESTINAL SERVICES	344,290	0	0	0	0	76.02
76.03	03030	ANGIOCARDIOGRAPHY	0	0	0	0	0	76.03
76.05	03954	INPATIENT RENAL DIALYSIS	0	0	0	0	0	76.05
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LI THOTRI PSY	0	0	0	0	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES	0	0	0	0	0	90.01
90.02	04950	WOUND CARE	425,187	0	0	0	0	90.02
90.03	09003	RIVER FOREST	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	742,424	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	399,759	0	0	0	0	92.00
200.00		Subtotal (see instructions)	8,248,669	0	17,066	0	6,645	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0			201.00
202.00		Net Charges (line 200 +/- line 201)	8,248,669	0	17,066	0	6,645	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 14-0008 Component CCN: 14-S008		Period: From 07/01/2016 To 06/30/2017		Worksheet D Part II Date/Time Prepared: 11/30/2017 8:36 am	
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	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	650,741	25,581,986	0.025437	785	20	50.00
51.00	05100 RECOVERY ROOM	34,175	11,185,865	0.003055	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	135,059	2,182,688	0.061877	7	0	52.00
53.00	05300 ANESTHESIOLOGY	14,242	20,588,650	0.000692	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	203,103	20,148,417	0.010080	28,271	285	54.00
56.00	05600 RADIOISOTOPE	37,437	6,664,937	0.005617	0	0	56.00
56.01	03630 ULTRASOUND	41,189	11,140,680	0.003697	10,075	37	56.01
57.00	05700 CT SCAN	32,618	48,017,072	0.000679	61,221	42	57.00
58.00	05800 MRI	46,987	13,234,965	0.003550	62,582	222	58.00
59.00	05900 CARDIAC CATHETERIZATION	44,954	14,732,028	0.003051	4,066	12	59.00
60.00	06000 LABORATORY	240,103	85,794,225	0.002799	493,150	1,380	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	32,309	11,565,744	0.002794	37,725	105	65.00
66.00	06600 PHYSICAL THERAPY	410,247	23,911,930	0.017157	92,307	1,584	66.00
67.00	06700 OCCUPATIONAL THERAPY	33,389	5,184,382	0.006440	15,006	97	67.00
68.00	06800 SPEECH PATHOLOGY	20,307	2,108,929	0.009629	12,676	122	68.00
69.00	06900 ELECTROCARDIOLOGY	44,215	17,292,431	0.002557	11,832	30	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	20,405	2,075,005	0.009834	19,127	188	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	95,456	9,854,629	0.009686	245	2	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	83,140	15,404,118	0.005397	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	72,335	23,561,208	0.003070	140,412	431	73.00
73.01	07301 OUTPATIENT PHARMACY	0	0	0.000000	0	0	73.01
74.00	07400 RENAL DIALYSIS	1,869	678,757	0.002754	0	0	74.00
76.00	03950 LI THOTRI PSY	0	0	0.000000	0	0	76.00
76.01	03951 CARDIAC REHABILITATION	68,792	1,054,703	0.065224	0	0	76.01
76.02	03020 GASTROINTESTINAL SERVICES	81,284	11,348,313	0.007163	0	0	76.02
76.03	03030 ANGIOCARDIOGRAPHY	0	0	0.000000	0	0	76.03
76.05	03954 INPATIENT RENAL DIALYSIS	0	0	0.000000	0	0	76.05
76.97	07697 CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699 LI THOTRI PSY	0	0	0.000000	0	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	1,693	13,790	0.122770	0	0	90.00
90.01	09001 OUTPATIENT INFUSION PROCEDURES	0	0	0.000000	0	0	90.01
90.02	04950 WOUND CARE	47,256	3,311,331	0.014271	0	0	90.02
90.03	09003 RIVER FOREST	0	0	0.000000	0	0	90.03
91.00	09100 EMERGENCY	249,927	51,274,861	0.004874	94,236	459	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	9,185,002	0.000000	1,690	0	92.00
200.00	Total (lines 50-199)	2,743,232	447,096,646		1,085,413	5,016	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0008 Component CCN: 14-S008	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part IV Date/Time Prepared: 11/30/2017 8:36 am
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	Title XVIII	Subprovider - IPF	PPS
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Cost Center Description		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600 RADIOISOTOPE	0	0	0	0	0	56.00
56.01	03630 ULTRASOUND	0	0	0	0	0	56.01
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MRI	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301 OUTPATIENT PHARMACY	0	0	0	0	0	73.01
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950 LI THOTRI PSY	0	0	0	0	0	76.00
76.01	03951 CARDIAC REHABILITATION	0	0	0	0	0	76.01
76.02	03020 GASTROINTESTINAL SERVICES	0	0	0	0	0	76.02
76.03	03030 ANGIOCARDIOGRAPHY	0	0	0	0	0	76.03
76.05	03954 INPATIENT RENAL DIALYSIS	0	0	0	0	0	76.05
76.97	07697 CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699 LI THOTRI PSY	0	0	0	0	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0	0	0	0	0	90.00
90.01	09001 OUTPATIENT INFUSION PROCEDURES	0	0	0	0	0	90.01
90.02	04950 WOUND CARE	0	0	0	0	0	90.02
90.03	09003 RIVER FOREST	0	0	0	0	0	90.03
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00	Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0008 Component CCN: 14-S008	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part IV Date/Time Prepared: 11/30/2017 8:36 am
Title XVIII		Subprovider - IPF	PPS

Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
	6.00	7.00	8.00	9.00	10.00	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	0	25,581,986	0.000000	0.000000	785	50.00
51.00 05100 RECOVERY ROOM	0	11,185,865	0.000000	0.000000	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	2,182,688	0.000000	0.000000	7	52.00
53.00 05300 ANESTHESIOLOGY	0	20,588,650	0.000000	0.000000	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	20,148,417	0.000000	0.000000	28,271	54.00
56.00 05600 RADIOISOTOPE	0	6,664,937	0.000000	0.000000	0	56.00
56.01 03630 ULTRASOUND	0	11,140,680	0.000000	0.000000	10,075	56.01
57.00 05700 CT SCAN	0	48,017,072	0.000000	0.000000	61,221	57.00
58.00 05800 MRI	0	13,234,965	0.000000	0.000000	62,582	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	14,732,028	0.000000	0.000000	4,066	59.00
60.00 06000 LABORATORY	0	85,794,225	0.000000	0.000000	493,150	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0.000000	0	62.30
65.00 06500 RESPIRATORY THERAPY	0	11,565,744	0.000000	0.000000	37,725	65.00
66.00 06600 PHYSICAL THERAPY	0	23,911,930	0.000000	0.000000	92,307	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	5,184,382	0.000000	0.000000	15,006	67.00
68.00 06800 SPEECH PATHOLOGY	0	2,108,929	0.000000	0.000000	12,676	68.00
69.00 06900 ELECTROCARDIOLOGY	0	17,292,431	0.000000	0.000000	11,832	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	2,075,005	0.000000	0.000000	19,127	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	9,854,629	0.000000	0.000000	245	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	15,404,118	0.000000	0.000000	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	23,561,208	0.000000	0.000000	140,412	73.00
73.01 07301 OUTPATIENT PHARMACY	0	0	0.000000	0.000000	0	73.01
74.00 07400 RENAL DIALYSIS	0	678,757	0.000000	0.000000	0	74.00
76.00 03950 LI THOTRI PSY	0	0	0.000000	0.000000	0	76.00
76.01 03951 CARDIAC REHABILITATION	0	1,054,703	0.000000	0.000000	0	76.01
76.02 03020 GASTROINTESTINAL SERVICES	0	11,348,313	0.000000	0.000000	0	76.02
76.03 03030 ANGIOCARDIOGRAPHY	0	0	0.000000	0.000000	0	76.03
76.05 03954 INPATIENT RENAL DIALYSIS	0	0	0.000000	0.000000	0	76.05
76.97 07697 CARDIAC REHABILITATION	0	0	0.000000	0.000000	0	76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0.000000	0	76.98
76.99 07699 LI THOTRI PSY	0	0	0.000000	0.000000	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000 CLINIC	0	13,790	0.000000	0.000000	0	90.00
90.01 09001 OUTPATIENT INFUSION PROCEDURES	0	0	0.000000	0.000000	0	90.01
90.02 04950 WOUND CARE	0	3,311,331	0.000000	0.000000	0	90.02
90.03 09003 RIVER FOREST	0	0	0.000000	0.000000	0	90.03
91.00 09100 EMERGENCY	0	51,274,861	0.000000	0.000000	94,236	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	9,185,002	0.000000	0.000000	1,690	92.00
200.00 Total (lines 50-199)	0	447,096,646			1,085,413	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0008 Component CCN: 14-S008	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part IV Date/Time Prepared: 11/30/2017 8:36 am
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Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges before Geographical Reclassification	Outpatient Program Charges on/after Geographical Reclassification	Outpatient Program Pass-Through Costs (col. 9 x col. 12) before Geographical Reclassification	Outpatient Program Pass-Through Costs (col. 9 x col. 12) on/after Geographical Reclassification	
		11.00	12.00	12.01	13.00	13.01	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600 RADIO SOTOPE	0	0	0	0	0	56.00
56.01	03630 ULTRASOUND	0	0	0	0	0	56.01
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MRI	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301 OUTPATIENT PHARMACY	0	0	0	0	0	73.01
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950 LI THOTRI PSY	0	0	0	0	0	76.00
76.01	03951 CARDIAC REHABILITATION	0	0	0	0	0	76.01
76.02	03020 GASTROINTESTINAL SERVICES	0	0	0	0	0	76.02
76.03	03030 ANGIOCARDIOGRAPHY	0	0	0	0	0	76.03
76.05	03954 INPATIENT RENAL DIALYSIS	0	0	0	0	0	76.05
76.97	07697 CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699 LI THOTRI PSY	0	0	0	0	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0	0	0	0	0	90.00
90.01	09001 OUTPATIENT INFUSION PROCEDURES	0	0	0	0	0	90.01
90.02	04950 WOUND CARE	0	0	0	0	0	90.02
90.03	09003 RIVER FOREST	0	0	0	0	0	90.03
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00	Total (Lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 14-0008 Component CCN: 14-T008		Period: From 07/01/2016 To 06/30/2017		Worksheet D Part II Date/Time Prepared: 11/30/2017 8:36 am	
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	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	650,741	25,581,986	0.025437	18,915	481	50.00
51.00	05100 RECOVERY ROOM	34,175	11,185,865	0.003055	674	2	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	135,059	2,182,688	0.061877	7	0	52.00
53.00	05300 ANESTHESIOLOGY	14,242	20,588,650	0.000692	913	1	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	203,103	20,148,417	0.010080	39,788	401	54.00
56.00	05600 RADIOISOTOPE	37,437	6,664,937	0.005617	2,417	14	56.00
56.01	03630 ULTRASOUND	41,189	11,140,680	0.003697	37,752	140	56.01
57.00	05700 CT SCAN	32,618	48,017,072	0.000679	93,820	64	57.00
58.00	05800 MRI	46,987	13,234,965	0.003550	53,373	189	58.00
59.00	05900 CARDIAC CATHETERIZATION	44,954	14,732,028	0.003051	6,817	21	59.00
60.00	06000 LABORATORY	240,103	85,794,225	0.002799	591,607	1,656	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	32,309	11,565,744	0.002794	383,548	1,072	65.00
66.00	06600 PHYSICAL THERAPY	410,247	23,911,930	0.017157	1,206,841	20,706	66.00
67.00	06700 OCCUPATIONAL THERAPY	33,389	5,184,382	0.006440	824,633	5,311	67.00
68.00	06800 SPEECH PATHOLOGY	20,307	2,108,929	0.009629	309,256	2,978	68.00
69.00	06900 ELECTROCARDIOLOGY	44,215	17,292,431	0.002557	42,202	108	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	20,405	2,075,005	0.009834	5,680	56	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	95,456	9,854,629	0.009686	62,836	609	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	83,140	15,404,118	0.005397	1,192	6	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	72,335	23,561,208	0.003070	409,557	1,257	73.00
73.01	07301 OUTPATIENT PHARMACY	0	0	0.000000	0	0	73.01
74.00	07400 RENAL DIALYSIS	1,869	678,757	0.002754	54,520	150	74.00
76.00	03950 LI THOTRI PSY	0	0	0.000000	0	0	76.00
76.01	03951 CARDIAC REHABILITATION	68,792	1,054,703	0.065224	0	0	76.01
76.02	03020 GASTROINTESTINAL SERVICES	81,284	11,348,313	0.007163	2,292	16	76.02
76.03	03030 ANGIOCARDIOGRAPHY	0	0	0.000000	0	0	76.03
76.05	03954 INPATIENT RENAL DIALYSIS	0	0	0.000000	0	0	76.05
76.97	07697 CARDIAC REHABILITATION	0	0	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0	0	76.98
76.99	07699 LI THOTRI PSY	0	0	0.000000	0	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	1,693	13,790	0.122770	0	0	90.00
90.01	09001 OUTPATIENT INFUSION PROCEDURES	0	0	0.000000	0	0	90.01
90.02	04950 WOUND CARE	47,256	3,311,331	0.014271	322	5	90.02
90.03	09003 RIVER FOREST	0	0	0.000000	0	0	90.03
91.00	09100 EMERGENCY	249,927	51,274,861	0.004874	10,478	51	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	9,185,002	0.000000	99	0	92.00
200.00	Total (lines 50-199)	2,743,232	447,096,646		4,159,539	35,294	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0008 Component CCN: 14-T008	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part IV Date/Time Prepared: 11/30/2017 8:36 am
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	Title XVIII	Subprovider - IRF	PPS
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Cost Center Description	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
	1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	0	0	0	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00 05600 RADIOISOTOPE	0	0	0	0	0	56.00
56.01 03630 ULTRASOUND	0	0	0	0	0	56.01
57.00 05700 CT SCAN	0	0	0	0	0	57.00
58.00 05800 MRI	0	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000 LABORATORY	0	0	0	0	0	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01 07301 OUTPATIENT PHARMACY	0	0	0	0	0	73.01
74.00 07400 RENAL DIALYSIS	0	0	0	0	0	74.00
76.00 03950 LI THOTRI PSY	0	0	0	0	0	76.00
76.01 03951 CARDIAC REHABILITATION	0	0	0	0	0	76.01
76.02 03020 GASTROINTESTINAL SERVICES	0	0	0	0	0	76.02
76.03 03030 ANGIOCARDIOGRAPHY	0	0	0	0	0	76.03
76.05 03954 INPATIENT RENAL DIALYSIS	0	0	0	0	0	76.05
76.97 07697 CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99 07699 LI THOTRI PSY	0	0	0	0	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000 CLINIC	0	0	0	0	0	90.00
90.01 09001 OUTPATIENT INFUSION PROCEDURES	0	0	0	0	0	90.01
90.02 04950 WOUND CARE	0	0	0	0	0	90.02
90.03 09003 RIVER FOREST	0	0	0	0	0	90.03
91.00 09100 EMERGENCY	0	0	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00 Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0008 Component CCN: 14-T008	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part IV Date/Time Prepared: 11/30/2017 8:36 am
Title XVIII		Subprovider - IRF	PPS

Cost Center Description	Total	Total Charges	Ratio of Cost	Outpatient	Inpatient	
	Outpatient Cost (sum of col. 2, 3 and 4)	(from Wkst. C, Part I, col. 8)	to Charges (col. 5 ÷ col. 7)	Ratio of Cost to Charges (col. 6 ÷ col. 7)	Program Charges	
	6.00	7.00	8.00	9.00	10.00	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	0	25,581,986	0.000000	0.000000	18,915	50.00
51.00 05100 RECOVERY ROOM	0	11,185,865	0.000000	0.000000	674	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	2,182,688	0.000000	0.000000	7	52.00
53.00 05300 ANESTHESIOLOGY	0	20,588,650	0.000000	0.000000	913	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	20,148,417	0.000000	0.000000	39,788	54.00
56.00 05600 RADIOISOTOPE	0	6,664,937	0.000000	0.000000	2,417	56.00
56.01 03630 ULTRASOUND	0	11,140,680	0.000000	0.000000	37,752	56.01
57.00 05700 CT SCAN	0	48,017,072	0.000000	0.000000	93,820	57.00
58.00 05800 MRI	0	13,234,965	0.000000	0.000000	53,373	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	14,732,028	0.000000	0.000000	6,817	59.00
60.00 06000 LABORATORY	0	85,794,225	0.000000	0.000000	591,607	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0.000000	0	62.30
65.00 06500 RESPIRATORY THERAPY	0	11,565,744	0.000000	0.000000	383,548	65.00
66.00 06600 PHYSICAL THERAPY	0	23,911,930	0.000000	0.000000	1,206,841	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	5,184,382	0.000000	0.000000	824,633	67.00
68.00 06800 SPEECH PATHOLOGY	0	2,108,929	0.000000	0.000000	309,256	68.00
69.00 06900 ELECTROCARDIOLOGY	0	17,292,431	0.000000	0.000000	42,202	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	2,075,005	0.000000	0.000000	5,680	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	9,854,629	0.000000	0.000000	62,836	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	15,404,118	0.000000	0.000000	1,192	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	23,561,208	0.000000	0.000000	409,557	73.00
73.01 07301 OUTPATIENT PHARMACY	0	0	0.000000	0.000000	0	73.01
74.00 07400 RENAL DIALYSIS	0	678,757	0.000000	0.000000	54,520	74.00
76.00 03950 LI THOTRI PSY	0	0	0.000000	0.000000	0	76.00
76.01 03951 CARDIAC REHABILITATION	0	1,054,703	0.000000	0.000000	0	76.01
76.02 03020 GASTROINTESTINAL SERVICES	0	11,348,313	0.000000	0.000000	2,292	76.02
76.03 03030 ANGIOCARDIOGRAPHY	0	0	0.000000	0.000000	0	76.03
76.05 03954 INPATIENT RENAL DIALYSIS	0	0	0.000000	0.000000	0	76.05
76.97 07697 CARDIAC REHABILITATION	0	0	0.000000	0.000000	0	76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0.000000	0	76.98
76.99 07699 LI THOTRI PSY	0	0	0.000000	0.000000	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000 CLINIC	0	13,790	0.000000	0.000000	0	90.00
90.01 09001 OUTPATIENT INFUSION PROCEDURES	0	0	0.000000	0.000000	0	90.01
90.02 04950 WOUND CARE	0	3,311,331	0.000000	0.000000	322	90.02
90.03 09003 RIVER FOREST	0	0	0.000000	0.000000	0	90.03
91.00 09100 EMERGENCY	0	51,274,861	0.000000	0.000000	10,478	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	9,185,002	0.000000	0.000000	99	92.00
200.00 Total (lines 50-199)	0	447,096,646			4,159,539	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0008 Component CCN: 14-T008	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part IV Date/Time Prepared: 11/30/2017 8:36 am
Title XVIII		Subprovider - IRF	PPS

Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges before Geographical Reconciliation	Outpatient Program Charges on/after Geographical Reconciliation	Outpatient Program Pass-Through Costs (col. 9 x col. 12) before Geographical Reconciliation	Outpatient Program Pass-Through Costs (col. 9 x col. 12) on/after Geographical Reconciliation	
	11.00	12.00	12.01	13.00	13.01	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	0	6	0	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	1	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	2,003	0	0	0	54.00
56.00 05600 RADIO SOTOPE	0	0	0	0	0	56.00
56.01 03630 ULTRASOUND	0	1,115	0	0	0	56.01
57.00 05700 CT SCAN	0	2,591	0	0	0	57.00
58.00 05800 MRI	0	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	245	0	0	0	59.00
60.00 06000 LABORATORY	0	331	0	0	0	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00 06500 RESPIRATORY THERAPY	0	583	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	84	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01 07301 OUTPATIENT PHARMACY	0	0	0	0	0	73.01
74.00 07400 RENAL DIALYSIS	0	0	0	0	0	74.00
76.00 03950 LI THOTRI PSY	0	0	0	0	0	76.00
76.01 03951 CARDIAC REHABILITATION	0	0	0	0	0	76.01
76.02 03020 GASTROINTESTINAL SERVICES	0	0	0	0	0	76.02
76.03 03030 ANGIOCARDIOGRAPHY	0	0	0	0	0	76.03
76.05 03954 INPATIENT RENAL DIALYSIS	0	0	0	0	0	76.05
76.97 07697 CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99 07699 LI THOTRI PSY	0	0	0	0	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000 CLINIC	0	0	0	0	0	90.00
90.01 09001 OUTPATIENT INFUSION PROCEDURES	0	0	0	0	0	90.01
90.02 04950 WOUND CARE	0	0	0	0	0	90.02
90.03 09003 RIVER FOREST	0	0	0	0	0	90.03
91.00 09100 EMERGENCY	0	7	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00 Total (Lines 50-199)	0	6,966	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-0008 Component CCN: 14-T008	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part V Date/Time Prepared: 11/30/2017 8:36 am
	Title XVIII	Subprovider - IRF	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges				
		PPS Reimbursed Services (see inst.) before Geo Recl assi fi cat ion	PPS Reimbursed Services (see inst.) on/after Geo Recl assi fi cat ion	Cost Reimbursed Services Subject To Ded. & Coi ns. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coi ns. (see inst.)	
		1.00	2.00	2.01	3.00	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	0.365523	6	0	0	0	50.00
51.00 05100 RECOVERY ROOM	0.081759	0	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.672772	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0.008615	1	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.161667	2,003	0	0	0	54.00
56.00 05600 RADIOISOTOPE	0.067546	0	0	0	0	56.00
56.01 03630 ULTRASOUND	0.085437	1,115	0	0	0	56.01
57.00 05700 CT SCAN	0.020607	2,591	0	0	0	57.00
58.00 05800 MRI	0.049892	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0.073647	245	0	0	0	59.00
60.00 06000 LABORATORY	0.096533	331	0	0	0	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00 06500 RESPIRATORY THERAPY	0.152115	583	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0.205413	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0.101726	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0.187572	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0.051791	0	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0.110711	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1.002130	84	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.554653	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.260822	0	0	0	0	73.00
73.01 07301 OUTPATIENT PHARMACY	0.000000	0	0	0	0	73.01
74.00 07400 RENAL DIALYSIS	0.908246	0	0	0	0	74.00
76.00 03950 LI THOTRI PSY	0.000000	0	0	0	0	76.00
76.01 03951 CARDIAC REHABILITATION	0.602531	0	0	0	0	76.01
76.02 03020 GASTROINTESTINAL SERVICES	0.139028	0	0	0	0	76.02
76.03 03030 ANGIOCARDIOGRAPHY	0.000000	0	0	0	0	76.03
76.05 03954 INPATIENT RENAL DIALYSIS	0.000000	0	0	0	0	76.05
76.97 07697 CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99 07699 LI THOTRI PSY	0.000000	0	0	0	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000 CLINIC	0.508267	0	0	0	0	90.00
90.01 09001 OUTPATIENT INFUSION PROCEDURES	0.000000	0	0	0	0	90.01
90.02 04950 WOUND CARE	0.352192	0	0	0	0	90.02
90.03 09003 RIVER FOREST	0.000000	0	0	0	0	90.03
91.00 09100 EMERGENCY	0.123313	7	0	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.255261	0	0	0	0	92.00
200.00 Subtotal (see instructions)		6,966	0	0	0	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges					0	201.00
202.00 Net Charges (line 200 +/- line 201)		6,966	0	0	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-0008 Component CCN: 14-T008	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part V Date/Time Prepared: 11/30/2017 8:36 am
	Title XVIII	Subprovider - IRF	PPS

Cost Center Description	Costs					
	PPS Services (see inst.) before Geographical Classification	PPS Services (see inst.) on/after Geographical Classification	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	5.00	5.01	6.00	7.00		
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	2	0	0	0		50.00
51.00 05100 RECOVERY ROOM	0	0	0	0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0		52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	324	0	0	0		54.00
56.00 05600 RADIO SOTOPE	0	0	0	0		56.00
56.01 03630 ULTRASOUND	95	0	0	0		56.01
57.00 05700 CT SCAN	53	0	0	0		57.00
58.00 05800 MRI	0	0	0	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	18	0	0	0		59.00
60.00 06000 LABORATORY	32	0	0	0		60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0		62.30
65.00 06500 RESPIRATORY THERAPY	89	0	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0		68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	84	0	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0		73.00
73.01 07301 OUTPATIENT PHARMACY	0	0	0	0		73.01
74.00 07400 RENAL DIALYSIS	0	0	0	0		74.00
76.00 03950 LI THOTRI PSY	0	0	0	0		76.00
76.01 03951 CARDIAC REHABILITATION	0	0	0	0		76.01
76.02 03020 GASTROINTESTINAL SERVICES	0	0	0	0		76.02
76.03 03030 ANGIOCARDIOGRAPHY	0	0	0	0		76.03
76.05 03954 INPATIENT RENAL DIALYSIS	0	0	0	0		76.05
76.97 07697 CARDIAC REHABILITATION	0	0	0	0		76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0	0	0		76.98
76.99 07699 LI THOTRI PSY	0	0	0	0		76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000 CLINIC	0	0	0	0		90.00
90.01 09001 OUTPATIENT INFUSION PROCEDURES	0	0	0	0		90.01
90.02 04950 WOUND CARE	0	0	0	0		90.02
90.03 09003 RIVER FOREST	0	0	0	0		90.03
91.00 09100 EMERGENCY	1	0	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0		92.00
200.00 Subtotal (see instructions)	698	0	0	0		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0			201.00
202.00 Net Charges (line 200 +/- line 201)	698	0	0	0		202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0008 Component CCN: 14-5526	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part IV Date/Time Prepared: 11/30/2017 8:36 am
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	Title XVIII	Skilled Nursing Facility	PPS
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Cost Center Description		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600 RADIOISOTOPE	0	0	0	0	0	56.00
56.01	03630 ULTRASOUND	0	0	0	0	0	56.01
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MRI	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301 OUTPATIENT PHARMACY	0	0	0	0	0	73.01
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950 LI THOTRI PSY	0	0	0	0	0	76.00
76.01	03951 CARDIAC REHABILITATION	0	0	0	0	0	76.01
76.02	03020 GASTROINTESTINAL SERVICES	0	0	0	0	0	76.02
76.03	03030 ANGIOCARDIOGRAPHY	0	0	0	0	0	76.03
76.05	03954 INPATIENT RENAL DIALYSIS	0	0	0	0	0	76.05
76.97	07697 CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699 LI THOTRI PSY	0	0	0	0	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>							
90.00	09000 CLINIC	0	0	0	0	0	90.00
90.01	09001 OUTPATIENT INFUSION PROCEDURES	0	0	0	0	0	90.01
90.02	04950 WOUND CARE	0	0	0	0	0	90.02
90.03	09003 RIVER FOREST	0	0	0	0	0	90.03
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00	Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0008 Component CCN: 14-5526	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part IV Date/Time Prepared: 11/30/2017 8:36 am
Title XVIII		Skilled Nursing Facility	PPS

Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
	6.00	7.00	8.00	9.00	10.00	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	0	25,581,986	0.000000	0.000000	65,627	50.00
51.00 05100 RECOVERY ROOM	0	11,185,865	0.000000	0.000000	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	2,182,688	0.000000	0.000000	13	52.00
53.00 05300 ANESTHESIOLOGY	0	20,588,650	0.000000	0.000000	38,055	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	20,148,417	0.000000	0.000000	137,436	54.00
56.00 05600 RADIOISOTOPE	0	6,664,937	0.000000	0.000000	20,711	56.00
56.01 03630 ULTRASOUND	0	11,140,680	0.000000	0.000000	92,605	56.01
57.00 05700 CT SCAN	0	48,017,072	0.000000	0.000000	130,604	57.00
58.00 05800 MRI	0	13,234,965	0.000000	0.000000	38,011	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	14,732,028	0.000000	0.000000	47,710	59.00
60.00 06000 LABORATORY	0	85,794,225	0.000000	0.000000	826,723	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000	0.000000	0	62.30
65.00 06500 RESPIRATORY THERAPY	0	11,565,744	0.000000	0.000000	660,257	65.00
66.00 06600 PHYSICAL THERAPY	0	23,911,930	0.000000	0.000000	2,266,399	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	5,184,382	0.000000	0.000000	1,512,765	67.00
68.00 06800 SPEECH PATHOLOGY	0	2,108,929	0.000000	0.000000	567,175	68.00
69.00 06900 ELECTROCARDIOLOGY	0	17,292,431	0.000000	0.000000	54,950	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	2,075,005	0.000000	0.000000	6,816	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	9,854,629	0.000000	0.000000	270,685	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	15,404,118	0.000000	0.000000	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	23,561,208	0.000000	0.000000	752,259	73.00
73.01 07301 OUTPATIENT PHARMACY	0	0	0.000000	0.000000	0	73.01
74.00 07400 RENAL DIALYSIS	0	678,757	0.000000	0.000000	0	74.00
76.00 03950 LI THOTRI PSY	0	0	0.000000	0.000000	0	76.00
76.01 03951 CARDIAC REHABILITATION	0	1,054,703	0.000000	0.000000	0	76.01
76.02 03020 GASTROINTESTINAL SERVICES	0	11,348,313	0.000000	0.000000	0	76.02
76.03 03030 ANGIOCARDIOGRAPHY	0	0	0.000000	0.000000	0	76.03
76.05 03954 INPATIENT RENAL DIALYSIS	0	0	0.000000	0.000000	0	76.05
76.97 07697 CARDIAC REHABILITATION	0	0	0.000000	0.000000	0	76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0	0.000000	0.000000	0	76.98
76.99 07699 LI THOTRI PSY	0	0	0.000000	0.000000	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000 CLINIC	0	13,790	0.000000	0.000000	0	90.00
90.01 09001 OUTPATIENT INFUSION PROCEDURES	0	0	0.000000	0.000000	0	90.01
90.02 04950 WOUND CARE	0	3,311,331	0.000000	0.000000	0	90.02
90.03 09003 RIVER FOREST	0	0	0.000000	0.000000	0	90.03
91.00 09100 EMERGENCY	0	51,274,861	0.000000	0.000000	7,177	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	9,185,002	0.000000	0.000000	0	92.00
200.00 Total (lines 50-199)	0	447,096,646			7,495,978	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 14-0008 Component CCN: 14-5526	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part IV Date/Time Prepared: 11/30/2017 8:36 am
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Cost Center Description			Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges before Geographical Reclassification	Outpatient Program Charges on/after Geographical Reclassification	Outpatient Program Pass-Through Costs (col. 9 x col. 12) before Geographical Reclassification	Outpatient Program Pass-Through Costs (col. 9 x col. 12) on/after Geographical Reclassification	
			11.00	12.00	12.01	13.00	13.01	
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
56.00	05600	RADIOLOGY	0	0	0	0	0	56.00
56.01	03630	ULTRASOUND	0	0	0	0	0	56.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
73.01	07301	OUTPATIENT PHARMACY	0	0	0	0	0	73.01
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950	LI THOTRI PSY	0	0	0	0	0	76.00
76.01	03951	CARDIAC REHABILITATION	0	0	0	0	0	76.01
76.02	03020	GASTROINTESTINAL SERVICES	0	0	0	0	0	76.02
76.03	03030	ANGIOCARDIOGRAPHY	0	0	0	0	0	76.03
76.05	03954	INPATIENT RENAL DIALYSIS	0	0	0	0	0	76.05
76.97	07697	CARDIAC REHABILITATION	0	0	0	0	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76.98
76.99	07699	LI THOTRI PSY	0	0	0	0	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES	0	0	0	0	0	90.01
90.02	04950	WOUND CARE	0	0	0	0	0	90.02
90.03	09003	RIVER FOREST	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
200.00		Total (Lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-0008 Component CCN: 14-5526	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part V Date/Time Prepared: 11/30/2017 8:36 am
	Title XVIII	Skilled Nursing Facility	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges				
		PPS Reimbursed Services (see inst.) before Geo Recl assi fi cat ion	PPS Reimbursed Services (see inst.) on/after Geo Recl assi fi cat ion	Cost Reimbursed Services Subject To Ded. & Coi ns. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coi ns. (see inst.)	
		1.00	2.00	2.01	3.00	
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	0.365523	0	0	0	0	50.00
51.00 05100 RECOVERY ROOM	0.081759	0	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.672772	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0.008615	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0.161667	0	0	0	0	54.00
56.00 05600 RADIOISOTOPE	0.067546	0	0	0	0	56.00
56.01 03630 ULTRASOUND	0.085437	0	0	0	0	56.01
57.00 05700 CT SCAN	0.020607	0	0	0	0	57.00
58.00 05800 MRI	0.049892	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0.073647	0	0	0	0	59.00
60.00 06000 LABORATORY	0.096533	0	0	373	0	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	0	0	62.30
65.00 06500 RESPIRATORY THERAPY	0.152115	0	0	1	0	65.00
66.00 06600 PHYSICAL THERAPY	0.205413	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0.101726	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0.187572	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0.051791	0	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0.110711	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1.002130	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0.554653	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.260822	0	0	0	0	73.00
73.01 07301 OUTPATIENT PHARMACY	0.000000	0	0	0	0	73.01
74.00 07400 RENAL DIALYSIS	0.908246	0	0	0	0	74.00
76.00 03950 LI THOTRI PSY	0.000000	0	0	0	0	76.00
76.01 03951 CARDIAC REHABILITATION	0.602531	0	0	0	0	76.01
76.02 03020 GASTROINTESTINAL SERVICES	0.139028	0	0	0	0	76.02
76.03 03030 ANGIOCARDIOGRAPHY	0.000000	0	0	0	0	76.03
76.05 03954 INPATIENT RENAL DIALYSIS	0.000000	0	0	0	0	76.05
76.97 07697 CARDIAC REHABILITATION	0.000000	0	0	0	0	76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	0	0	76.98
76.99 07699 LI THOTRI PSY	0.000000	0	0	0	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000 CLINIC	0.508267	0	0	0	0	90.00
90.01 09001 OUTPATIENT INFUSION PROCEDURES	0.000000	0	0	0	0	90.01
90.02 04950 WOUND CARE	0.352192	0	0	0	0	90.02
90.03 09003 RIVER FOREST	0.000000	0	0	0	0	90.03
91.00 09100 EMERGENCY	0.123313	0	0	6	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.255261	0	0	0	0	92.00
200.00 Subtotal (see instructions)		0	0	380	0	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges				0	0	201.00
202.00 Net Charges (line 200 +/- line 201)		0	0	380	0	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 14-0008 Component CCN: 14-5526	Period: From 07/01/2016 To 06/30/2017	Worksheet D Part V Date/Time Prepared: 11/30/2017 8:36 am
	Title XVIII	Skilled Nursing Facility	PPS

Cost Center Description	Costs					
	PPS Services (see inst.) before Geographical Reclassification	PPS Services (see inst.) on/after Geographical Reclassification	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	5.00	5.01	6.00	7.00		
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000 OPERATING ROOM	0	0	0	0		50.00
51.00 05100 RECOVERY ROOM	0	0	0	0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0		52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0		54.00
56.00 05600 RADIO SOTOP	0	0	0	0		56.00
56.01 03630 ULTRASOUND	0	0	0	0		56.01
57.00 05700 CT SCAN	0	0	0	0		57.00
58.00 05800 MRI	0	0	0	0		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0		59.00
60.00 06000 LABORATORY	0	0	36	0		60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0		62.30
65.00 06500 RESPIRATORY THERAPY	0	0	0	0		65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0		68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0		73.00
73.01 07301 OUTPATIENT PHARMACY	0	0	0	0		73.01
74.00 07400 RENAL DIALYSIS	0	0	0	0		74.00
76.00 03950 LI THOTRI PSY	0	0	0	0		76.00
76.01 03951 CARDIAC REHABILITATION	0	0	0	0		76.01
76.02 03020 GASTROINTESTINAL SERVICES	0	0	0	0		76.02
76.03 03030 ANGIOCARDIOGRAPHY	0	0	0	0		76.03
76.05 03954 INPATIENT RENAL DIALYSIS	0	0	0	0		76.05
76.97 07697 CARDIAC REHABILITATION	0	0	0	0		76.97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0	0	0	0		76.98
76.99 07699 LI THOTRI PSY	0	0	0	0		76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>						
90.00 09000 CLINIC	0	0	0	0		90.00
90.01 09001 OUTPATIENT INFUSION PROCEDURES	0	0	0	0		90.01
90.02 04950 WOUND CARE	0	0	0	0		90.02
90.03 09003 RIVER FOREST	0	0	0	0		90.03
91.00 09100 EMERGENCY	0	0	1	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0		92.00
200.00 Subtotal (see instructions)	0	0	37	0		200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges			0			201.00
202.00 Net Charges (line 200 +/- line 201)	0	0	37	0		202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0008	Period: From 07/01/2016 To 06/30/2017	Worksheet D-1 Date/Time Prepared: 11/30/2017 8:36 am
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		23,941	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		23,941	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)		21,598	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		9,942	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
<b>SWING BED ADJUSTMENT</b>				
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)		23,956,983	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)		23,956,983	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
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)		23,956,983	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,000.67	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		9,948,661	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		9,948,661	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 14-0008	Period: From 07/01/2016 To 06/30/2017	Worksheet D-1 Date/Time Prepared: 11/30/2017 8:36 am	
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	5,484,954	3,786	1,448.75	1,799	2,606,301	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)					13,078,991	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					25,633,953	49.00
PASS THROUGH COST ADJUSTMENTS						
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					2,179,048	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					424,341	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					2,603,389	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					23,030,564	53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00 Program discharges					0	54.00
55.00 Target amount per discharge					0.00	55.00
56.00 Target amount (line 54 x line 55)					0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00 Bonus payment (see instructions)					0	58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00 Relief payment (see instructions)					0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00 Program routine service cost (line 9 x line 71)						72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00 Program capital-related costs (line 9 x line 76)						77.00
78.00 Inpatient routine service cost (line 74 minus line 77)						78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00 Inpatient routine service cost per diem limitation						81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00 Reasonable inpatient routine service costs (see instructions)						83.00
84.00 Program inpatient ancillary services (see instructions)						84.00
85.00 Utilization review - physician compensation (see instructions)						85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00 Total observation bed days (see instructions)					2,343	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,000.67	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					2,344,570	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0008		Period: From 07/01/2016 To 06/30/2017		Worksheet D-1 Date/Time Prepared: 11/30/2017 8:36 am	
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	4,964,351	23,956,983	0.207219	2,344,570	485,839	90.00
91.00	Nursing School cost	0	23,956,983	0.000000	2,344,570	0	91.00
92.00	Allied health cost	0	23,956,983	0.000000	2,344,570	0	92.00
93.00	All other Medical Education	0	23,956,983	0.000000	2,344,570	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0008 Component CCN: 14-S008	Period: From 07/01/2016 To 06/30/2017	Worksheet D-1 Date/Time Prepared: 11/30/2017 8:36 am
		Title XVIII	Subprovider - IPF	PPS
Cost Center Description				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2,839	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2,839	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		2,839	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		2,758	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
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		2,156,140	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2,156,140	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		2,156,140	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		759.47	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,094,618	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		2,094,618	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0008	Period: From 07/01/2016 To 06/30/2017	Worksheet D-1	
				Component CCN: 14-S008	Date/Time Prepared: 11/30/2017 8:36 am		
				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)					138,268	48.00	
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					2,232,886	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)					111,368	50.00	
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					5,016	51.00	
52.00 Total Program excludable cost (sum of lines 50 and 51)					116,384	52.00	
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthesiologist, and medical education costs (line 49 minus line 52)					2,116,502	53.00	
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges					0	54.00	
55.00 Target amount per discharge					0.00	55.00	
56.00 Target amount (line 54 x line 55)					0	56.00	
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00	
58.00 Bonus payment (see instructions)					0	58.00	
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00	
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00	
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00	
62.00 Relief payment (see instructions)					0	62.00	
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00	
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00	
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00	
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00	
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00	
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00	
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00	
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00	
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00	
72.00 Program routine service cost (line 9 x line 71)						72.00	
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00	
74.00 Total Program general inpatient routine service costs (line 72 + line 73)						74.00	
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00	
76.00 Per diem capital-related costs (line 75 ÷ line 2)						76.00	
77.00 Program capital-related costs (line 9 x line 76)						77.00	
78.00 Inpatient routine service cost (line 74 minus line 77)						78.00	
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)						79.00	
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00	
81.00 Inpatient routine service cost per diem limitation						81.00	
82.00 Inpatient routine service cost limitation (line 9 x line 81)						82.00	
83.00 Reasonable inpatient routine service costs (see instructions)						83.00	
84.00 Program inpatient ancillary services (see instructions)						84.00	
85.00 Utilization review - physician compensation (see instructions)						85.00	
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)						86.00	
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)					0	87.00	
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00	
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0	89.00	

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0008 Component CCN: 14-S008		Period: From 07/01/2016 To 06/30/2017		Worksheet D-1 Date/Time Prepared: 11/30/2017 8:36 am	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	114,651	2,156,140	0.053174	0	0	90.00
91.00	Nursing School cost	0	2,156,140	0.000000	0	0	91.00
92.00	Allied health cost	0	2,156,140	0.000000	0	0	92.00
93.00	All other Medical Education	0	2,156,140	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0008 Component CCN: 14-T008	Period: From 07/01/2016 To 06/30/2017	Worksheet D-1 Date/Time Prepared: 11/30/2017 8:36 am
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		5,777	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		5,777	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)		5,777	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		2,797	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
<b>SWING BED ADJUSTMENT</b>				
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)		5,503,359	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)		5,503,359	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
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)		5,503,359	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		952.63	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,664,506	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		2,664,506	41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0008	Period: From 07/01/2016 To 06/30/2017	Worksheet D-1	
				Component CCN: 14-T008		Date/Time Prepared: 11/30/2017 8:36 am	
				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)					751,683	48.00	
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					3,416,189	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)					617,997	50.00	
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					35,294	51.00	
52.00 Total Program excludable cost (sum of lines 50 and 51)					653,291	52.00	
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthesiologist, and medical education costs (line 49 minus line 52)					2,762,898	53.00	
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges					0	54.00	
55.00 Target amount per discharge					0.00	55.00	
56.00 Target amount (line 54 x line 55)					0	56.00	
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00	
58.00 Bonus payment (see instructions)					0	58.00	
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00	
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00	
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00	
62.00 Relief payment (see instructions)					0	62.00	
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00	
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00	
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00	
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00	
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00	
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00	
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00	
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70.00	
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00	
72.00 Program routine service cost (line 9 x line 71)						72.00	
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00	
74.00 Total Program general inpatient routine service costs (line 72 + line 73)						74.00	
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00	
76.00 Per diem capital-related costs (line 75 ÷ line 2)						76.00	
77.00 Program capital-related costs (line 9 x line 76)						77.00	
78.00 Inpatient routine service cost (line 74 minus line 77)						78.00	
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)						79.00	
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00	
81.00 Inpatient routine service cost per diem limitation						81.00	
82.00 Inpatient routine service cost limitation (line 9 x line 81)						82.00	
83.00 Reasonable inpatient routine service costs (see instructions)						83.00	
84.00 Program inpatient ancillary services (see instructions)						84.00	
85.00 Utilization review - physician compensation (see instructions)						85.00	
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)						86.00	
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)					0	87.00	
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00	
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0	89.00	

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0008 Component CCN: 14-T008		Period: From 07/01/2016 To 06/30/2017		Worksheet D-1 Date/Time Prepared: 11/30/2017 8:36 am	
		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	1,276,435	5,503,359	0.231937	0	0	90.00
91.00	Nursing School cost	0	5,503,359	0.000000	0	0	91.00
92.00	Allied health cost	0	5,503,359	0.000000	0	0	92.00
93.00	All other Medical Education	0	5,503,359	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0008 Component CCN: 14-5526	Period: From 07/01/2016 To 06/30/2017	Worksheet D-1 Date/Time Prepared: 11/30/2017 8:36 am
		Title XVIII	Skilled Nursing Facility	PPS
Cost Center Description				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		9,007	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		9,007	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		9,007	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		6,360	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
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		6,484,053	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		6,484,053	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		6,484,053	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			41.00

COMPUTATION OF INPATIENT OPERATING COST				Provider CCN: 14-0008 Component CCN: 14-5526	Period: From 07/01/2016 To 06/30/2017	Worksheet D-1 Date/Time Prepared: 11/30/2017 8:36 am
				Title XVIII	Skilled Nursing Facility	PPS
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
42.00 NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00	42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT						43.00
44.00 CORONARY CARE UNIT						44.00
45.00 BURN INTENSIVE CARE UNIT						45.00
46.00 SURGICAL INTENSIVE CARE UNIT						46.00
47.00 OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description					1.00	
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						49.00
PASS THROUGH COST ADJUSTMENTS						
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)						52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthesiologist, and medical education costs (line 49 minus line 52)						53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00 Program discharges						54.00
55.00 Target amount per discharge						55.00
56.00 Target amount (line 54 x line 55)						56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						57.00
58.00 Bonus payment (see instructions)						58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						61.00
62.00 Relief payment (see instructions)						62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)						63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY						
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)					6,484,053	70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)					719.89	71.00
72.00 Program routine service cost (line 9 x line 71)					4,578,500	72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)					0	73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)					4,578,500	74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					0	75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)					0.00	76.00
77.00 Program capital-related costs (line 9 x line 76)					0	77.00
78.00 Inpatient routine service cost (line 74 minus line 77)					0	78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)					0	79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)					0	80.00
81.00 Inpatient routine service cost per diem limitation					0.00	81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)					0	82.00
83.00 Reasonable inpatient routine service costs (see instructions)					4,578,500	83.00
84.00 Program inpatient ancillary services (see instructions)					1,441,973	84.00
85.00 Utilization review - physician compensation (see instructions)					0	85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)					6,020,473	86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00 Total observation bed days (see instructions)					0	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 14-0008 Component CCN: 14-5526		Period: From 07/01/2016 To 06/30/2017		Worksheet D-1 Date/Time Prepared: 11/30/2017 8:36 am	
		Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0008	Period: From 07/01/2016 To 06/30/2017	Worksheet D-3 Date/Time Prepared: 11/30/2017 8:36 am	
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		29,493,584	30.00
31.00	03100	INTENSIVE CARE UNIT		7,350,313	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.365523	3,894,957	50.00
51.00	05100	RECOVERY ROOM	0.081759	1,730,650	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.672772	4,233	52.00
53.00	05300	ANESTHESIOLOGY	0.008615	3,240,070	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.161667	2,376,676	54.00
56.00	05600	RADIOISOTOPE	0.067546	965,689	56.00
56.01	03630	ULTRASOUND	0.085437	1,191,402	56.01
57.00	05700	CT SCAN	0.020607	6,208,958	57.00
58.00	05800	MRI	0.049892	1,146,793	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.073647	2,895,716	59.00
60.00	06000	LABORATORY	0.096533	13,637,182	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.152115	4,160,728	65.00
66.00	06600	PHYSICAL THERAPY	0.205413	1,503,761	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.101726	573,909	67.00
68.00	06800	SPEECH PATHOLOGY	0.187572	157,647	68.00
69.00	06900	ELECTROCARDIOLOGY	0.051791	4,197,063	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.110711	158,416	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.002130	2,265,795	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.554653	4,861,719	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.260822	6,084,222	73.00
73.01	07301	OUTPATIENT PHARMACY	0.000000	0	73.01
74.00	07400	RENAL DIALYSIS	0.908246	202,494	74.00
76.00	03950	LITHOTRIPSY	0.000000	0	76.00
76.01	03951	CARDIAC REHABILITATION	0.602531	580	76.01
76.02	03020	GASTROINTESTINAL SERVICES	0.139028	1,063,259	76.02
76.03	03030	ANGIOCARDIOGRAPHY	0.000000	0	76.03
76.05	03954	INPATIENT RENAL DIALYSIS	0.000000	0	76.05
76.97	07697	CARDIAC REHABILITATION	0.000000	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	76.98
76.99	07699	LITHOTRIPSY	0.000000	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.508267	0	90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES	0.000000	0	90.01
90.02	04950	WOUND CARE	0.352192	3,941	90.02
90.03	09003	RIVER FOREST	0.000000	0	90.03
91.00	09100	EMERGENCY	0.123313	5,913,894	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.255261	1,314,130	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		69,753,884	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)		69,753,884	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0008 Component CCN: 14-S008	Period: From 07/01/2016 To 06/30/2017	Worksheet D-3 Date/Time Prepared: 11/30/2017 8:36 am	
		Title XVIII	Subprovider - IPF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
40.00	04000	SUBPROVIDER - IPF		6,563,931	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
43.00	04300	NURSERY		0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.365523	785	50.00
51.00	05100	RECOVERY ROOM	0.081759	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.672772	7	52.00
53.00	05300	ANESTHESIOLOGY	0.008615	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.161667	28,271	54.00
56.00	05600	RADIOISOTOPE	0.067546	0	56.00
56.01	03630	ULTRASOUND	0.085437	10,075	56.01
57.00	05700	CT SCAN	0.020607	61,221	57.00
58.00	05800	MRI	0.049892	62,582	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.073647	4,066	59.00
60.00	06000	LABORATORY	0.096533	493,150	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.152115	37,725	65.00
66.00	06600	PHYSICAL THERAPY	0.205413	92,307	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.101726	15,006	67.00
68.00	06800	SPEECH PATHOLOGY	0.187572	12,676	68.00
69.00	06900	ELECTROCARDIOLOGY	0.051791	11,832	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.110711	19,127	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.002130	245	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.554653	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.260822	140,412	73.00
73.01	07301	OUTPATIENT PHARMACY	0.000000	0	73.01
74.00	07400	RENAL DIALYSIS	0.908246	0	74.00
76.00	03950	LI THOTRI PSY	0.000000	0	76.00
76.01	03951	CARDIAC REHABILITATION	0.602531	0	76.01
76.02	03020	GASTROINTESTINAL SERVICES	0.139028	0	76.02
76.03	03030	ANGIOCARDIOGRAPHY	0.000000	0	76.03
76.05	03954	INPATIENT RENAL DIALYSIS	0.000000	0	76.05
76.97	07697	CARDIAC REHABILITATION	0.000000	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	76.98
76.99	07699	LI THOTRI PSY	0.000000	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	0.508267	0	90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES	0.000000	0	90.01
90.02	04950	WOUND CARE	0.352192	0	90.02
90.03	09003	RIVER FOREST	0.000000	0	90.03
91.00	09100	EMERGENCY	0.123313	94,236	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.255261	1,690	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		1,085,413	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net charges (line 200 minus line 201)		1,085,413	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0008 Component CCN: 14-T008	Period: From 07/01/2016 To 06/30/2017	Worksheet D-3 Date/Time Prepared: 11/30/2017 8:36 am	
		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	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
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		6,204,999		41.00
43.00	04300 NURSERY				43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0.365523	18,915	6,914	50.00
51.00	05100 RECOVERY ROOM	0.081759	674	55	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.672772	7	5	52.00
53.00	05300 ANESTHESIOLOGY	0.008615	913	8	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.161667	39,788	6,432	54.00
56.00	05600 RADIOISOTOPE	0.067546	2,417	163	56.00
56.01	03630 ULTRASOUND	0.085437	37,752	3,225	56.01
57.00	05700 CT SCAN	0.020607	93,820	1,933	57.00
58.00	05800 MRI	0.049892	53,373	2,663	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.073647	6,817	502	59.00
60.00	06000 LABORATORY	0.096533	591,607	57,110	60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	0	62.30
65.00	06500 RESPIRATORY THERAPY	0.152115	383,548	58,343	65.00
66.00	06600 PHYSICAL THERAPY	0.205413	1,206,841	247,901	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.101726	824,633	83,887	67.00
68.00	06800 SPEECH PATHOLOGY	0.187572	309,256	58,008	68.00
69.00	06900 ELECTROCARDIOLOGY	0.051791	42,202	2,186	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.110711	5,680	629	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1.002130	62,836	62,970	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.554653	1,192	661	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.260822	409,557	106,821	73.00
73.01	07301 OUTPATIENT PHARMACY	0.000000	0	0	73.01
74.00	07400 RENAL DIALYSIS	0.908246	54,520	49,518	74.00
76.00	03950 LI THOTRI PSY	0.000000	0	0	76.00
76.01	03951 CARDIAC REHABILITATION	0.602531	0	0	76.01
76.02	03020 GASTROINTESTINAL SERVICES	0.139028	2,292	319	76.02
76.03	03030 ANGIOCARDIOGRAPHY	0.000000	0	0	76.03
76.05	03954 INPATIENT RENAL DIALYSIS	0.000000	0	0	76.05
76.97	07697 CARDIAC REHABILITATION	0.000000	0	0	76.97
76.98	07698 HYPERBARIC OXYGEN THERAPY	0.000000	0	0	76.98
76.99	07699 LI THOTRI PSY	0.000000	0	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000 CLINIC	0.508267	0	0	90.00
90.01	09001 OUTPATIENT INFUSION PROCEDURES	0.000000	0	0	90.01
90.02	04950 WOUND CARE	0.352192	322	113	90.02
90.03	09003 RIVER FOREST	0.000000	0	0	90.03
91.00	09100 EMERGENCY	0.123313	10,478	1,292	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.255261	99	25	92.00
200.00	Total (sum of lines 50 through 94 and 96 through 98)		4,159,539	751,683	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0		201.00
202.00	Net charges (line 200 minus line 201)		4,159,539		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 14-0008 Component CCN: 14-5526	Period: From 07/01/2016 To 06/30/2017	Worksheet D-3 Date/Time Prepared: 11/30/2017 8:36 am	
		Title XVIII	Skilled Nursing Facility	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
43.00	04300	NURSERY		0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.365523	65,627	50.00
51.00	05100	RECOVERY ROOM	0.081759	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.672772	13	52.00
53.00	05300	ANESTHESIOLOGY	0.008615	38,055	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.161667	137,436	54.00
56.00	05600	RADIOISOTOPE	0.067546	20,711	56.00
56.01	03630	ULTRASOUND	0.085437	92,605	56.01
57.00	05700	CT SCAN	0.020607	130,604	57.00
58.00	05800	MRI	0.049892	38,011	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.073647	47,710	59.00
60.00	06000	LABORATORY	0.096533	826,723	60.00
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0	62.30
65.00	06500	RESPIRATORY THERAPY	0.152115	660,257	65.00
66.00	06600	PHYSICAL THERAPY	0.205413	2,266,399	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.101726	1,512,765	67.00
68.00	06800	SPEECH PATHOLOGY	0.187572	567,175	68.00
69.00	06900	ELECTROCARDIOLOGY	0.051791	54,950	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.110711	6,816	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.002130	270,685	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.554653	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.260822	752,259	73.00
73.01	07301	OUTPATIENT PHARMACY	0.000000	0	73.01
74.00	07400	RENAL DIALYSIS	0.908246	0	74.00
76.00	03950	LI THOTRI PSY	0.000000	0	76.00
76.01	03951	CARDIAC REHABILITATION	0.602531	0	76.01
76.02	03020	GASTROINTESTINAL SERVICES	0.139028	0	76.02
76.03	03030	ANGIOCARDIOGRAPHY	0.000000	0	76.03
76.05	03954	INPATIENT RENAL DIALYSIS	0.000000	0	76.05
76.97	07697	CARDIAC REHABILITATION	0.000000	0	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY	0.000000	0	76.98
76.99	07699	LI THOTRI PSY	0.000000	0	76.99
<b>OUTPATIENT SERVICE COST CENTERS</b>					
90.00	09000	CLINIC	0.508267	0	90.00
90.01	09001	OUTPATIENT INFUSION PROCEDURES	0.000000	0	90.01
90.02	04950	WOUND CARE	0.352192	0	90.02
90.03	09003	RIVER FOREST	0.000000	0	90.03
91.00	09100	EMERGENCY	0.123313	7,177	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.255261	0	92.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		7,495,978	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)		7,495,978	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0008	Period: From 07/01/2016 To 06/30/2017	Worksheet E Part A Date/Time Prepared: 11/30/2017 8:36 am	
		Title XVIII	Hospital	PPS	
		Before GEO Reclass	1.00	On/After GEO Reclass	1.01
<b>PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS</b>					
1.00	DRG Amounts Other than Outlier Payments		0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		22,837,535	0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		0	0	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0	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	0	1.04
2.00	Outlier payments for discharges. (see instructions)		25,621	0	2.00
2.01	Outlier reconciliation amount		0	0	2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0	0	2.02
3.00	Managed Care Simulated Payments		7,476,992	0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		157.48		4.00
<b>Indirect Medical Education Adjustment</b>					
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)		2.54		5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00		6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00		7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.57		7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00		8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 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 section 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)		1.97		9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		4.93		10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00		11.00
12.00	Current year allowable FTE (see instructions)		1.97		12.00
13.00	Total allowable FTE count for the prior year.		2.02		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.		1.97		14.00
15.00	Sum of lines 12 through 14 divided by 3.		1.99		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		1.99		18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.012637		19.00
20.00	Prior year resident to bed ratio (see instructions)		0.011698		20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.011698		21.00
22.00	IME payment adjustment (see instructions)		145,544	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)		47,651	0	22.01
<b>Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA</b>					
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00		23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		2.96		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	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0	0	28.01
29.00	Total IME payment ( sum of lines 22 and 28)		145,544	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		47,651	0	29.01
<b>Disproportionate Share Adjustment</b>					
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		4.05		30.00
31.00	Percentage of Medicaid patient days (see instructions)		17.00		31.00
32.00	Sum of lines 30 and 31		21.05		32.00
33.00	Allowable disproportionate share percentage (see instructions)		6.58	6.58	33.00
34.00	Disproportionate share adjustment (see instructions)		375,678	0	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0008	Period: From 07/01/2016 To 06/30/2017	Worksheet E Part A Date/Time Prepared: 11/30/2017 8:36 am	
		Title XVIII	Hospital	PPS	
		Prior to 10/1	On/After 10/1		
		1.00	2.00		
<b>Uncompensated Care Adjustment</b>					
35.00	Total uncompensated care amount (see instructions)	6,406,145,534	5,977,483,147	35.00	
35.01	Factor 3 (see instructions)	0.000186256	0.000185344	35.01	
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	1,193,185	1,107,890	35.02	
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	299,926	828,641	35.03	
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,128,567		36.00	
<b>Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)</b>					
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 GEO Recl ass	On/After GEO Recl ass		
		1.00	1.01		
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0	0	41.00	
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0	0	41.01	
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00	
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)	0		43.00	
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00	
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	0.00	45.00	
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00	
47.00	Subtotal (see instructions)	24,512,945	0	47.00	
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)	0	0	48.00	
				Amount	
				1.00	
49.00	Total payment for inpatient operating costs (see instructions)		24,560,596	49.00	
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		1,942,388	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).		64,857	52.00	
53.00	Nursing and Allied Health Managed Care payment		0	53.00	
54.00	Special add-on payments for new technologies		2,368	54.00	
54.01	Islet isolation add-on payment		0	54.01	
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00	
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0	56.00	
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		0	57.00	
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		0	58.00	
59.00	Total (sum of amounts on lines 49 through 58)		26,570,209	59.00	
60.00	Primary payer payments		8,647	60.00	
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		26,561,562	61.00	
62.00	Deductibles billed to program beneficiaries		2,406,628	62.00	
63.00	Coinurance billed to program beneficiaries		120,512	63.00	
64.00	Allowable bad debts (see instructions)		521,890	64.00	
65.00	Adjusted reimbursable bad debts (see instructions)		339,229	65.00	
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		347,815	66.00	
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		24,373,651	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 DEMONSTRATION PROJECT		0	70.50	
70.88	SCH or MDH volume decrease adjustment		0	70.88	
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0	70.89	
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	70.90	
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	70.91	
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92	
70.93	HVBP payment adjustment amount (see instructions)		-125,178	70.93	
70.94	HRR adjustment amount (see instructions)		-41,566	70.94	
70.95	Recovery of accelerated depreciation		0	70.95	

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0008	Period: From 07/01/2016 To 06/30/2017	Worksheet E Part A Date/Time Prepared: 11/30/2017 8:36 am	
		Title XVIII	Hospital	PPS	
		FFY (yyyy)	Amount		
		0	1.00		
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0		0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0		0	70.97
70.98	Low Volume Payment-3			0	70.98
70.99	HAC adjustment amount (see instructions)			0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)			24,206,907	71.00
71.01	Sequestration adjustment (see instructions)			484,138	71.01
72.00	Interim payments			23,606,255	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, 72, and 73)			116,514	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			538,825	75.00
<b>TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)</b>					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)			0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2			0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)			0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)			0	93.00
94.00	The rate used to calculate the time value of money (see instructions)			0.00	94.00
95.00	Time value of money for operating expenses (see instructions)			0	95.00
96.00	Time value of money for capital related expenses (see instructions)			0	96.00
			Prior to 10/1	On/After 10/1	
			1.00	2.00	
<b>HSP Bonus Payment Amount</b>					
100.00	HSP bonus amount (see instructions)			0	100.00
<b>HVBP Adjustment for HSP Bonus Payment</b>					
101.00	HVBP adjustment factor (see instructions)		0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)			0	102.00
<b>HRR Adjustment for HSP Bonus Payment</b>					
103.00	HRR adjustment factor (see instructions)		0.0000	0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)			0	104.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0008	Period: From 07/01/2016 To 06/30/2017	Worksheet E Part B Date/Time Prepared: 11/30/2017 8:36 am
		Title XVIII	Hospital	PPS
		before Geo Recl assi fi cat ion	on/after Geo Recl assi fi cat ion	
		1.00	1.01	
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)	23,711		1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	8,248,669	0	2.00
3.00	PPS payments	9,131,332	0	3.00
4.00	Outlier payment (see instructions)	10,841	0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	0.000	5.00
6.00	Line 2 times line 5	0	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0		9.00
10.00	Organ acquisitions	0		10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	23,711		11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges	42,917		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)	42,917		14.00
<b>Customary charges</b>				
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)	42,917		18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	19,206		19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	0		20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	23,711		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, 8 and 9)	9,142,173		24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance (for CAH, see instructions)	3,397		25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	1,819,526		26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	7,342,961		27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	13,598		28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0		29.00
30.00	Subtotal (sum of lines 27 through 29)	7,356,559		30.00
31.00	Primary payer payments	824		31.00
32.00	Subtotal (line 30 minus line 31)	7,355,735		32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Wkst. 1-5, line 11)	0		33.00
34.00	Allowable bad debts (see instructions)	430,024		34.00
35.00	Adjusted reimbursable bad debts (see instructions)	279,516		35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	297,173		36.00
37.00	Subtotal (see instructions)	7,635,251		37.00
38.00	MSP-LCC reconciliation amount from PS&R	0		38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0		39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0		39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0		39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0		39.99
40.00	Subtotal (see instructions)	7,635,251		40.00
40.01	Sequestration adjustment (see instructions)	152,705		40.01
41.00	Interim payments	7,461,157		41.00
42.00	Tentative settlement (for contractors use only)	0		42.00
43.00	Balance due provider/program (see instructions)	21,389		43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	86,535		44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
90.00	Original outlier amount (see instructions)	0		90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0		91.00
92.00	The rate used to calculate the Time Value of Money	0.00		92.00
93.00	Time Value of Money (see instructions)	0		93.00
94.00	Total (sum of lines 91 and 93)	0		94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0008 Component CCN: 14-T008	Period: From 07/01/2016 To 06/30/2017	Worksheet E Part B Date/Time Prepared: 11/30/2017 8:36 am
		Title XVIII	Subprovider - IRF	PPS
			before Geo Recl assi fi cat ion	on/after Geo Recl assi fi cat ion
			1.00	1.01
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		698	2.00
3.00	PPS payments		864	3.00
4.00	Outlier payment (see instructions)		0	4.00
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 line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		0	11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
<b>Customary charges</b>				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)		0	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)		864	24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		194	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)		670	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)		670	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		670	32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Wkst. 1-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		670	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.98	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)		670	40.00
40.01	Sequestration adjustment (see instructions)		13	40.01
41.00	Interim payments		656	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		1	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0008 Component CCN: 14-5526	Period: From 07/01/2016 To 06/30/2017	Worksheet E Part B Date/Time Prepared: 11/30/2017 8:36 am
		Title XVIII	Skilled Nursing Facility	PPS
			before Geo Recl assi fi cat ion	on/after Geo Recl assi fi cat ion
			1.00	1.01
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)		37	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		0	2.00
3.00	PPS payments			3.00
4.00	Outlier payment (see instructions)			4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)			5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		37	11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges		380	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)		380	14.00
<b>Customary charges</b>				
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)		380	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		343	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 (line 11 minus line 20) (for CAH see instructions)		37	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, 8 and 9)		0	24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance (for CAH, see instructions)		76	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		-39	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)		-39	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		-39	32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		0	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		0	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	36.00
37.00	Subtotal (see instructions)		-39	37.00
38.00	MSP-LCC reconciliation amount from PS&R			38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
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)		-39	40.00
40.01	Sequestration adjustment (see instructions)		0	40.01
41.00	Interim payments		298	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-337	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
90.00	Original outlier amount (see instructions)			90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			91.00
92.00	The rate used to calculate the Time Value of Money			92.00
93.00	Time Value of Money (see instructions)			93.00
94.00	Total (sum of lines 91 and 93)			94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0008

Period:  
From 07/01/2016  
To 06/30/2017

Worksheet E-1  
Part I  
Date/Time Prepared:  
11/30/2017 8:36 am

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		23,427,306		7,302,805	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	02/17/2017	178,949	02/17/2017	158,352		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)		178,949		158,352		3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		23,606,255		7,461,157		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		116,514		21,389		6.01
6.02	SETTLEMENT TO PROGRAM		0		0		6.02
7.00	Total Medicare program liability (see instructions)		23,722,769		7,482,546		7.00
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor						8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CCN: 14-0008 Component CCN: 14-S008	Period: From 07/01/2016 To 06/30/2017	Worksheet E-1 Part I Date/Time Prepared: 11/30/2017 8:36 am	
		Title XVIII	Subprovider - IPF	PPS	
		Inpatient Part A		Part B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount
		1.00	2.00	3.00	4.00
1.00	Total interim payments paid to provider				0 1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		2,420,459		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)				0 3.00
Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0 3.01
3.02			0		0 3.02
3.03			0		0 3.03
3.04			0		0 3.04
3.05			0		0 3.05
Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0 3.50
3.51			0		0 3.51
3.52			0		0 3.52
3.53			0		0 3.53
3.54			0		0 3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0 3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,420,459		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)				0 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)				0 6.00
6.01	SETTLEMENT TO PROVIDER		23,808		0 6.01
6.02	SETTLEMENT TO PROGRAM		0		0 6.02
7.00	Total Medicare program liability (see instructions)		2,444,267		0 7.00
				Contractor Number	NPR Date (Mo/Day/Yr)
			0	1.00	2.00
8.00	Name of Contractor				0 8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0008  
Component CCN: 14-T008

Period:  
From 07/01/2016  
To 06/30/2017

Worksheet E-1  
Part I  
Date/Time Prepared:  
11/30/2017 8:36 am

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					1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		4,292,170		656	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		4,292,170		656	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		220,406		1	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		4,512,576		657	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

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

Period:  
From 07/01/2016  
To 06/30/2017

Worksheet E-1  
Part I  
Date/Time Prepared:  
11/30/2017 8:36 am

Title XVIII

Skilled Nursing  
Facility

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider					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		3,364,340		298	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		3,364,340		298	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		26,850		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		337	6.02
7.00	Total Medicare program liability (see instructions)		3,391,190		-39	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 14-0008	Period: From 07/01/2016 To 06/30/2017	Worksheet E-1 Part II Date/Time Prepared: 11/30/2017 8:36 am
		Title XVIII	Hospital	PPS
				1.00
<b>TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS</b>				
<b>HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION</b>				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14		5,972	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12		11,741	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2		4,577	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12		25,384	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200		546,559,071	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20		4,277,658	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168		0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)		0	8.00
9.00	Sequestration adjustment amount (see instructions)		0	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)		0	10.00
<b>INPATIENT HOSPITAL SERVICES UNDER THE IPSS &amp; CAH</b>				
30.00	Initial/interim HIT payment adjustment (see instructions)		0	30.00
31.00	Other Adjustment (specify)		0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)		0	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0008 Component CCN: 14-S008	Period: From 07/01/2016 To 06/30/2017	Worksheet E-3 Part II Date/Time Prepared: 11/30/2017 8:36 am
		Title XVIII	Subprovider - IPF	PPS
				1.00
<b>PART II - MEDICARE PART A SERVICES - IPF PPS</b>				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)			2,606,110 1.00
2.00	Net IPF PPS Outlier Payments			0 2.00
3.00	Net IPF PPS ECT Payments			0 3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)			0.00 4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 4.01
5.00	New Teaching program adjustment. (see instructions)			0.00 5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)			0.00 8.00
9.00	Average Daily Census (see instructions)			7.778082 9.00
10.00	Teaching Adjustment Factor $\{(1 + (\text{line 8}/\text{line 9})) \text{ raised to the power of } .5150 - 1\}$ .			0.000000 10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).			0 11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)			2,606,110 12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)			0 13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)			0 14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)			0 15.00
16.00	Subtotal (see instructions)			2,606,110 16.00
17.00	Primary payer payments			0 17.00
18.00	Subtotal (line 16 less line 17).			2,606,110 18.00
19.00	Deductibles			124,796 19.00
20.00	Subtotal (line 18 minus line 19)			2,481,314 20.00
21.00	Coinsurance			11,452 21.00
22.00	Subtotal (line 20 minus line 21)			2,469,862 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			37,366 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			24,288 24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			27,456 25.00
26.00	Subtotal (sum of lines 22 and 24)			2,494,150 26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0 27.00
28.00	Other pass through costs (see instructions)			0 28.00
29.00	Outlier payments reconciliation			0 29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 30.50
30.99	Recovery of Accelerated Depreciation			0 30.99
31.00	Total amount payable to the provider (see instructions)			2,494,150 31.00
31.01	Sequestration adjustment (see instructions)			49,883 31.01
32.00	Interim payments			2,420,459 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, 32 and 33)			23,808 34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			6,442 35.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2			0 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0008 Component CCN: 14-T008	Period: From 07/01/2016 To 06/30/2017	Worksheet E-3 Part III Date/Time Prepared: 11/30/2017 8:36 am
		Title XVIII	Subprovider - IRF	PPS
				1.00
<b>PART III - MEDICARE PART A SERVICES - IRF PPS</b>				
1.00	Net Federal PPS Payment (see instructions)			4,401,242 1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0276 2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			224,903 3.00
4.00	Outlier Payments			82,607 4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)			0.00 5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 5.01
6.00	New Teaching program adjustment. (see instructions)			0.00 6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)			0.00 9.00
10.00	Average Daily Census (see instructions)			15.827397 10.00
11.00	Teaching Adjustment Factor (see instructions)			0.000000 11.00
12.00	Teaching Adjustment (see instructions)			0 12.00
13.00	Total PPS Payment (see instructions)			4,708,752 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)			0 15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)			0 16.00
17.00	Subtotal (see instructions)			4,708,752 17.00
18.00	Primary payer payments			0 18.00
19.00	Subtotal (line 17 less line 18).			4,708,752 19.00
20.00	Deductibles			17,024 20.00
21.00	Subtotal (line 19 minus line 20)			4,691,728 21.00
22.00	Coinurance			87,059 22.00
23.00	Subtotal (line 21 minus line 22)			4,604,669 23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			0 24.00
25.00	Adjusted reimbursable bad debts (see instructions)			0 25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 26.00
27.00	Subtotal (sum of lines 23 and 25)			4,604,669 27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0 28.00
29.00	Other pass through costs (see instructions)			0 29.00
30.00	Outlier payments reconciliation			0 30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 31.50
31.99	Recovery of Accelerated Depreciation			0 31.99
32.00	Total amount payable to the provider (see instructions)			4,604,669 32.00
32.01	Sequestration adjustment (see instructions)			92,093 32.01
33.00	Interim payments			4,292,170 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, 33, and 34)			220,406 35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			34,493 36.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4			82,607 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 14-0008 Component CCN: 14-5526	Period: From 07/01/2016 To 06/30/2017	Worksheet E-3 Part VI Date/Time Prepared: 11/30/2017 8:36 am
		Title XVIII	Skilled Nursing Facility	PPS
				1.00
PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES				
PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)				
1.00	Resource Utilization Group Payment (RUGS)		3,601,280	1.00
2.00	Routine service other pass through costs		0	2.00
3.00	Ancillary service other pass through costs		0	3.00
4.00	Subtotal (sum of lines 1 through 3)		3,601,280	4.00
COMPUTATION OF NET COST OF COVERED SERVICES				
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)			5.00
6.00	Deductible		0	6.00
7.00	Coinsurance		168,280	7.00
8.00	Allowable bad debts (see instructions)		42,150	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		27,398	9.00
10.00	Adjusted reimbursable bad debts (see instructions)		27,398	10.00
11.00	Utilization review		0	11.00
12.00	Subtotal (sum of lines 4, 5 minus lines 6 and 7, plus lines 10 and 11)(see instructions)		3,460,398	12.00
13.00	Inpatient primary payer payments		0	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	14.00
14.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	14.50
14.99	Recovery of Accelerated Depreciation		0	14.99
15.00	Subtotal (see instructions)		3,460,398	15.00
15.01	Sequestration adjustment (see instructions)		69,208	15.01
16.00	Interim payments		3,364,340	16.00
17.00	Tentative settlement (for contractor use only)		0	17.00
18.00	Balance due provider/program (line 15 minus lines 15.01, 16, and 17)		26,850	18.00
19.00	Protected amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, chapter 1, §115.2		21,893	19.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0008	Period: From 07/01/2016 To 06/30/2017	Worksheet E-4 Date/Time Prepared: 11/30/2017 8:36 am	
		Title XVIII	Hospital	PPS	
				1.00	
<b>COMPUTATION OF TOTAL DIRECT GME AMOUNT</b>					
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			1.54	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.23	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts)			1.31	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			4.93	6.00
7.00	Enter the lesser of line 5 or line 6			1.31	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	1.78	3.15	4.93	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	0.47	0.84	1.31	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00		10.00
10.01	Unweighted dental and podiatric resident FTE count for the current year		0.00		10.01
11.00	Total weighted FTE count	0.47	0.84		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.62	0.72		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.94	0.33		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	0.68	0.63		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
15.01	Unweighted adjustment for residents in initial years of new programs	0.00	0.00		15.01
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
16.01	Unweighted adjustment for residents displaced by program or hospital closure	0.00	0.00		16.01
17.00	Adjusted rolling average FTE count	0.68	0.63		17.00
18.00	Per resident amount	93,819.03	93,819.03		18.00
19.00	Approved amount for resident costs	63,797	59,106	122,903	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			3.62	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locally adjustment national average per resident amount (see instructions)			0.00	23.00
24.00	Multiply line 22 time line 23			0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			122,903	25.00
		Inpatient Part A	Managed care		
		1.00	2.00	3.00	
<b>COMPUTATION OF PROGRAM PATIENT LOAD</b>					
26.00	Inpatient Days (see instructions)	17,296	5,205		26.00
27.00	Total Inpatient Days (see instructions)	34,097	34,097		27.00
28.00	Ratio of inpatient days to total inpatient days	0.507259	0.152653		28.00
29.00	Program direct GME amount	62,344	18,762		29.00
30.00	Reduction for direct GME payments for Medicare Advantage		2,651		30.00
31.00	Net Program direct GME amount			78,455	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 14-0008	Period: From 07/01/2016 To 06/30/2017	Worksheet E-4 Date/Time Prepared: 11/30/2017 8:36 am
		Title XVIII	Hospital	PPS
				1.00
<b>DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)</b>				
32.00	Renal dialysis direct medical education costs (from Wkst. B, Pt. I, sum of col. 20 and 23, lines 74 and 94)		0	32.00
33.00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I, col. 8, sum of lines 74 and 94)		678,757	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)		0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)		0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)		0	36.00
<b>APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY</b>				
<b>Part A Reasonable Cost</b>				
37.00	Reasonable cost (see instructions)		39,462,808	37.00
38.00	Organ acquisition costs (Wkst. D-4, Pt. III, col. 1, line 69)		0	38.00
39.00	Cost of physicians' services in a teaching hospital (see instructions)		0	39.00
40.00	Primary payer payments (see instructions)		8,647	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)		39,454,161	41.00
<b>Part B Reasonable Cost</b>				
42.00	Reasonable cost (see instructions)		8,273,115	42.00
43.00	Primary payer payments (see instructions)		824	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)		8,272,291	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)		47,726,452	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)		0.826673	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)		0.173327	47.00
<b>ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B</b>				
48.00	Total program GME payment (line 31)		78,455	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (title XVIII only) (see instructions)		64,857	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)		13,598	50.00

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

Provider CCN: 14-0008

Period:  
From 07/01/2016  
To 06/30/2017

Worksheet G  
Date/Time Prepared:  
11/30/2017 8:36 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
<b>CURRENT ASSETS</b>						
1.00	Cash on hand in banks	6,504,935	0	0	0	1.00
2.00	Temporary investments	19,364,619	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	17,391,127	0	0	0	4.00
5.00	Other receivable	59,712,998	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-4,233,747	0	0	0	6.00
7.00	Inventory	3,397,000	0	0	0	7.00
8.00	Prepaid expenses	177,901	0	0	0	8.00
9.00	Other current assets	6,044,263	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	108,359,096	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	12,500,000	0	0	0	12.00
13.00	Land improvements	1,005,174	0	0	0	13.00
14.00	Accumulated depreciation	-333,311	0	0	0	14.00
15.00	Buildings	69,756,535	0	0	0	15.00
16.00	Accumulated depreciation	-23,084,459	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	44,962,204	0	0	0	23.00
24.00	Accumulated depreciation	-24,646,064	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)	80,160,079	0	0	0	30.00
<b>OTHER ASSETS</b>						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	2,314,690	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	2,314,690	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	190,833,865	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	59,275,435	0	0	0	37.00
38.00	Salaries, wages, and fees payable	5,439,526	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	9,443,571	0	0	0	43.00
44.00	Other current liabilities	476,787	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	74,635,319	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	20,829,385	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	20,829,385	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	95,464,704	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	95,369,161				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)	95,369,161	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	190,833,865	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 14-0008

Period:  
From 07/01/2016  
To 06/30/2017

Worksheet G-1

Date/Time Prepared:  
11/30/2017 8:36 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		91,918,696			0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		3,450,465				2.00
3.00	Total (sum of line 1 and line 2)		95,369,161			0	3.00
4.00	Additions credit adjustments specify	0		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		0			0	10.00
11.00	Subtotal (line 3 plus line 10)		95,369,161			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)		95,369,161			0	19.00
		Endowment Fund	Plant Fund				
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions credit adjustments specify		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 14-0008

Period:  
From 07/01/2016  
To 06/30/2017

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
11/30/2017 8:36 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
General Inpatient Routine Services					
1.00	Hospital	59,758,626		59,758,626	1.00
2.00	SUBPROVIDER - IPF	6,730,992		6,730,992	2.00
3.00	SUBPROVIDER - IRF	6,982,303		6,982,303	3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	8,244,054		8,244,054	7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	81,715,975		81,715,975	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	14,358,162		14,358,162	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)	14,358,162		14,358,162	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	96,074,137		96,074,137	17.00
18.00	Ancillary services	198,057,336		198,057,336	18.00
19.00	Outpatient services	0	226,457,353	226,457,353	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
24.10	CORF	0	0	0	24.10
24.20	OUTPATIENT PHYSICAL THERAPY	0	0	0	24.20
24.30	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	24.30
24.40	OUTPATIENT SPEECH PATHOLOGY	0	0	0	24.40
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	DISCONTINUED HHA	0	-1,380	-1,380	27.00
27.02	OTHER PATIENT REVENUES	232	1,885,766	1,885,998	27.02
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	294,131,705	228,341,739	522,473,444	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		123,162,090		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)		123,162,090		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 14-0008

Period:  
From 07/01/2016  
To 06/30/2017

Worksheet G-3

Date/Time Prepared:  
11/30/2017 8:36 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	522,473,444	1.00
2.00	Less contractual allowances and discounts on patients' accounts	406,777,311	2.00
3.00	Net patient revenues (line 1 minus line 2)	115,696,133	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	123,162,090	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-7,465,957	5.00
<b>OTHER INCOME</b>			
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	18,662	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	1,993,338	22.00
23.00	Governmental appropriations	0	23.00
24.00	DAY CARE	2,232,142	24.00
24.01	MEDICARE EHR REVENUE	454,113	24.01
24.02	REFERENCE LAB	4,332,688	24.02
24.04	OTHER INCOME	1,885,479	24.04
25.00	Total other income (sum of lines 6-24)	10,916,422	25.00
26.00	Total (line 5 plus line 25)	3,450,465	26.00
27.00	Other expenses specify	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	3,450,465	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 14-0008	Period: From 07/01/2016 To 06/30/2017	Worksheet L Parts I-III Date/Time Prepared: 11/30/2017 8:36 am
		Title XVII	Hospital	PPS
			Urban	Rural
			1.00	1.01
<b>PART I - FULLY PROSPECTIVE METHOD</b>				
<b>CAPITAL FEDERAL AMOUNT</b>				
1.00	Capital DRG other than outlier		1,844,473	0
1.01	Model 4 BPCI Capital DRG other than outlier		0	0
2.00	Capital DRG outlier payments		2,740	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)		69.92	3.00
4.00	Number of interns & residents (see instructions)		1.99	4.00
5.00	Indirect medical education percentage (see instructions)		0.81	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)		14,940	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		4.05	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		17.00	8.00
9.00	Sum of lines 7 and 8		21.05	9.00
10.00	Allowable disproportionate share percentage (see instructions)		4.35	10.00
11.00	Disproportionate share adjustment (see instructions)		80,235	11.00
12.00	Total prospective capital payments (see instructions)		1,942,388	12.00
				1.00
<b>PART II - PAYMENT UNDER REASONABLE COST</b>				
1.00	Program inpatient routine capital cost (see instructions)			0
2.00	Program inpatient ancillary capital cost (see instructions)			0
3.00	Total inpatient program capital cost (line 1 plus line 2)			0
4.00	Capital cost payment factor (see instructions)			0
5.00	Total inpatient program capital cost (line 3 x line 4)			0
				1.00
<b>PART III - COMPUTATION OF EXCEPTION PAYMENTS</b>				
1.00	Program inpatient capital costs (see instructions)			0
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)			0
3.00	Net program inpatient capital costs (line 1 minus line 2)			0
4.00	Applicable exception percentage (see instructions)			0.00
5.00	Capital cost for comparison to payments (line 3 x line 4)			0
6.00	Percentage adjustment for extraordinary circumstances (see instructions)			0.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)			0
8.00	Capital minimum payment level (line 5 plus line 7)			0
9.00	Current year capital payments (from Part I, line 12, as applicable)			0
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)			0
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)			0
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)			0
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)			0
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
15.00	Current year allowable operating and capital payment (see instructions)			0
16.00	Current year operating and capital costs (see instructions)			0
17.00	Current year exception offset amount (see instructions)			0