

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 140213	Period: From 10/01/2013 To 09/30/2014	Worksheet S Parts I-III Date/Time Prepared: 2/25/2015 8:10 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: 2/25/2015 Time: 8:10 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 SILVER CROSS HOSPITAL ( 140213 ) for the cost reporting period beginning 10/01/2013 and ending 09/30/2014 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	-275,981	-268,004	28,661	0	1.00
2.00 Subprovider - IPF	0	78,737	0		0	2.00
3.00 Subprovider - IRF	0	15,642	182		0	3.00
4.00 SUBPROVIDER I	0	0	0		0	4.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
7.00 SKILLED NURSING FACILITY	0	0	0		0	7.00
8.00 NURSING FACILITY	0				0	8.00
9.00 HOME HEALTH AGENCY I	0	1	0		0	9.00
10.00 RURAL HEALTH CLINIC I	0		0		0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
12.00 CMHC I	0		0		0	12.00
200.00 Total	0	-181,601	-267,822	28,661	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-MEDI-CARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA					Provider CCN: 140213	Period: From 10/01/2013 To 09/30/2014	Worksheet S-2 Part I Date/Time Prepared: 2/25/2015 8:07 am				
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 1900 SILVER CROSS BLVD.			PO Box:						1.00	
2.00	City: NEW LENOX			State: IL		Zip Code: 60451		County: WILL		2.00	
		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00		
Hospital and Hospital-Based Component Identification:											
3.00	Hospital		SILVER CROSS HOSPITAL	140213	16974	1	07/01/1966	N	P	P	3.00
4.00	Subprovider - IPF		SCH - MENTAL HEALTH CARE UNIT	14S213	16974	4	04/01/1991	N	P	P	4.00
5.00	Subprovider - IRF		SCH - REHAB	14T213	16974	5	10/01/2000	N	P	P	5.00
6.00	Subprovider - (Other)										6.00
7.00	Swing Beds - SNF										7.00
8.00	Swing Beds - NF										8.00
9.00	Hospital-Based SNF										9.00
10.00	Hospital-Based NF										10.00
11.00	Hospital-Based OLTC										11.00
12.00	Hospital-Based HHA		SCH HOME HEALTH	147452	16974		04/01/1994	N	P	N	12.00
13.00	Separately Certified ASC										13.00
14.00	Hospital-Based Hospice										14.00
15.00	Hospital-Based Health Clinic - RHC										15.00
16.00	Hospital-Based Health Clinic - FQHC										16.00
17.00	Hospital-Based (CMHC) I										17.00
17.10	Hospital-Based (CORF) I										17.10
18.00	Renal Dialysis										18.00
18.01											18.01
18.02											18.02
19.00	Other										19.00
						From:		To:			
						1.00		2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)					10/01/2013		09/30/2014		20.00	
21.00	Type of Control (see instructions)							1		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 §412.06(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		22.01	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					1		N		23.00	
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days				
		1.00	2.00	3.00	4.00	5.00	6.00				
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	6,986	3,563	0	0	175	0		24.00		
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.	60	136	0	0	0	0		25.00		

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140213	Period: From 10/01/2013 To 09/30/2014	Worksheet S-2 Part I Date/Time Prepared: 2/25/2015 8:07 am		
		Urban/Rural S	Date of Geogr			
		1.00	2.00			
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	1			26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.	1			27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.	0			35.00	
		Beginning:	Ending:			
		1.00	2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.				36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0			37.00	
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for 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)				39.00	
		V	XVII	XIX		
		1.00	2.00	3.00		
<b>Prospective Payment System (PPS)-Capital</b>						
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 Worksheet L, Part III and L-1, Parts I through 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	
<b>Teaching Hospitals</b>						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00	
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.				57.00	
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.	N			58.00	
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part 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)	Y			60.00	
		Y/N	IME	Direct GME	IME	Direct GME
		1.00	2.00	3.00	4.00	5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00		61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		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

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		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		
<u>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</u>							
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	
<u>Teaching Hospitals that Claim Residents in Non-Provider Settings</u>							
63.00	Has your facility trained residents in non-provider 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 Nonprovi der Si te	Unweighted FTEs in Hospi tal	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 non-provider 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	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospi tal	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00

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		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))		
		1.00	2.00	3.00		
66.00	Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider 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		
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		
		1.00	2.00	3.00	4.00	5.00
70.00	Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			Y		
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. 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, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			N		0
75.00	Inpatient Rehabilitation Facility PPS Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			Y		
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, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			N		0
					1.00	
80.00	Long Term Care Hospital PPS Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.					N
85.00	TEFRA Providers Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.					N
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.					
				V	XIX	
				1.00	2.00	
90.00	Title V and XIX Services 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
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
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
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N		N
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N		N
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.				0.00	0.00

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		V	XIX			
		1.00	2.00			
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)	N			106.00	
107.00	Column 1: 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 would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N			107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N			108.00	
		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00
		1.00	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 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 hospital providers) based on the definition in CMS 15-1, §2208.1.	N		0	115.00	
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00	
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N			117.00	
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	0			118.00	
		Premiums	Losses	Insurance		
		1.00	2.00	3.00		
118.01	List amounts of malpractice premiums and paid losses:	0	0	0		118.01
		1.00	2.00			
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N			118.02	
119.00	DO NOT USE THIS LINE					119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.	N	N		120.00	
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y			121.00	
<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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140213	Period: From 10/01/2013 To 09/30/2014	Worksheet S-2 Part I Date/Time Prepared: 2/25/2015 8:07 am			
		1.00	2.00				
All Providers							
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y			140.00		
		1.00	2.00	3.00			
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.							
141.00	Name:	Contractor's Name:		Contractor's Number:			
142.00	Street:	PO Box:					
143.00	City:	State:		Zip Code:			
				1.00			
144.00	Are provider based physicians' costs included in Worksheet A?	Y			144.00		
145.00	If costs for renal services are claimed on Worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.	Y			145.00		
				1.00	2.00		
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N			146.00		
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N			147.00		
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N			148.00		
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N			149.00		
		Part A 1.00	Part B 2.00	Title V 3.00	Title XIX 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		
156.00	Subprovider - IPF	N	N	N	N		
157.00	Subprovider - IRF	N	N	N	N		
158.00	SUBPROVIDER						
159.00	SNF	N	N	N	N		
160.00	HOME HEALTH AGENCY	N	N	N	N		
161.00	CMHC		N	N	N		
161.10	CORF		N	N	N		
				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 0	County 1.00	State 2.00	Zip Code 3.00	CBSA 4.00	FTE/Campus 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						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 Section §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		
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)				0.75		
		Beginning 1.00		Ending 2.00			
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	10/01/2013		09/30/2014			

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 140213	Period: From 10/01/2013 To 09/30/2014	Worksheet S-2 Part II Date/Time Prepared: 2/25/2015 8:07 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		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	Y			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	N			9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
				Y/N	
				1.00	
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			Y	15.00
		Part A		Part B	
		Y/N	Date	Y/N	
		1.00	2.00	3.00	
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	01/26/2015	Y	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00
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



HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 140213

Period:  
From 10/01/2013  
To 09/30/2014

Worksheet S-2  
Part II  
Date/Time Prepared:  
2/25/2015 8:07 am

	Description	Part A		Part B	
		Y/N	Date	Y/N	
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			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
<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.			N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
<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.			N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
<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.			Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N	35.00
				Y/N	Date
				1.00	2.00
<b>Home Office Costs</b>					
36.00	Were home office costs claimed on the cost report?			Y	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			N	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N	40.00
				1.00	2.00
<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.	JOHN		KREPPS	41.00
42.00	Enter the employer/company name of the cost report preparer.	SILVER CROSS HOSPITAL			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	815-300-7084		JKREPPS@SILVERCROSS.ORG	43.00

		Part B	
		Date	
		4.00	
<b>PS&amp;R Data</b>			
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)		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	01/26/2015	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		21.00
		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.	VICE PRESIDENT OF FINANCE	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: 140213

Period:  
From 10/01/2013  
To 09/30/2014

Worksheet S-3  
Part I  
Date/Time Prepared:  
2/25/2015 8:07 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Avai lable	CAH Hours	I/P Days / O/P Vi si ts / 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	223	81,395	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)		223	81,395	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	28	10,220	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		251	91,615	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	14	5,110		0	16.00
17.00 SUBPROVIDER - IRF	41.00	24	8,760		0	17.00
18.00 SUBPROVIDER	42.00	0	0		0	18.00
19.00 SKILLED NURSING FACILITY	44.00	0	0		0	19.00
20.00 NURSING FACILITY	45.00	0	0		0	20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC	99.00				0	25.00
25.10 CMHC - CORF	99.10				0	25.10
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		289				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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 140213

Period:  
From 10/01/2013  
To 09/30/2014

Worksheet S-3  
Part I  
Date/Time Prepared:  
2/25/2015 8:07 am

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	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)	26,966	8,416	55,274			1.00
2.00 HMO and other (see instructions)	2,570	175				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	82	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)	26,966	8,416	55,274			7.00
8.00 INTENSIVE CARE UNIT	2,925	908	5,843			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		991	6,375			13.00
14.00 Total (see instructions)	29,891	10,315	67,492	0.00	1,544.10	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF	1,259	951	4,575	0.00	24.60	16.00
17.00 SUBPROVIDER - IRF	4,908	196	7,472	0.00	46.80	17.00
18.00 SUBPROVIDER	0	0	0	0.00	0.00	18.00
19.00 SKILLED NURSING FACILITY	0	0	0	0.00	0.00	19.00
20.00 NURSING FACILITY		0	0	0.00	0.00	20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	17,584	0	20,924	0.00	20.30	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	0	0	0	0.00	0.00	25.00
25.10 CMHC - CORF	0	0	0	0.00	0.00	25.10
26.00 RURAL HEALTH CLINIC	0	0	0	0.00	0.00	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00 Total (sum of lines 14-26)				0.00	1,635.80	27.00
28.00 Observation Bed Days		1,029	6,501			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)	0	234	1,504			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: 140213

Period:  
From 10/01/2013  
To 09/30/2014

Worksheet S-3  
Part I  
Date/Time Prepared:  
2/25/2015 8:07 am

Component	Full Time Equivalents	Discharges			Total All Patients	
		Title V	Title XVIII	Title XIX		
		11.00	12.00	13.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	7,081	3,454	20,495	1.00
2.00 HMO and other (see instructions)			599	42		2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	7,081	3,454	20,495	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	173	255	726	16.00
17.00 SUBPROVIDER - IRF	0.00	0	387	14	571	17.00
18.00 SUBPROVIDER	0.00	0	0	0	0	18.00
19.00 SKILLED NURSING FACILITY	0.00					19.00
20.00 NURSING FACILITY	0.00					20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0.00					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC	0.00					25.00
25.10 CMHC - CORF	0.00					25.10
26.00 RURAL HEALTH CLINIC	0.00					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION			Provider CCN: 140213	Period: From 10/01/2013 To 09/30/2014	Worksheet S-3 Part II Date/Time Prepared: 2/25/2015 8:07 am			
	Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)		
	1.00	2.00	3.00	4.00	5.00	6.00		
<b>PART II - WAGE DATA</b>								
<b>SALARIES</b>								
1.00	Total salaries (see instructions)	200.00	102,282,491	0	102,282,491	3,402,506.00	30.06	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		6,606,139	0	6,606,139	202,550.00	32.61	10.00
<b>OTHER WAGES &amp; RELATED COSTS</b>								
11.00	Contract labor: Direct Patient Care		3,454,556	0	3,454,556	58,549.00	59.00	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		161,932	0	161,932	1,496.00	108.24	13.00
14.00	Home office salaries & wage-related costs		5,931,358	0	5,931,358	19,760.00	300.17	14.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
<b>WAGE-RELATED COSTS</b>								
17.00	Wage-related costs (core) (see instructions)		31,645,883	0	31,645,883			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		2,185,045	0	2,185,045			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
<b>OVERHEAD COSTS - DIRECT SALARIES</b>								
26.00	Employee Benefits Department	4.00	608,075	0	608,075	17,742.00	34.27	26.00
27.00	Administrative & General	5.00	14,335,066	-275,750	14,059,316	457,891.00	30.70	27.00
28.00	Administrative & General under contract (see inst.)		213,264	0	213,264	1,831.50	116.44	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	2,695,521	0	2,695,521	109,346.00	24.65	30.00
31.00	Laundry & Linen Service	8.00	89,278	0	89,278	6,261.00	14.26	31.00
32.00	Housekeeping	9.00	2,068,128	0	2,068,128	146,058.00	14.16	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	1,763,477	-1,284,506	478,971	61,204.00	7.83	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	1,284,506	1,284,506	61,204.00	20.99	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,734,410	0	1,734,410	54,205.00	32.00	38.00
39.00	Central Services and Supply	14.00	1,307,624	-735,495	572,129	36,858.00	15.52	39.00
40.00	Pharmacy	15.00	2,720,974	0	2,720,974	62,899.00	43.26	40.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140213

Period:  
From 10/01/2013  
To 09/30/2014

Worksheet S-3  
Part II  
Date/Time Prepared:  
2/25/2015 8:07 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Sal ari es (from Worksheet A-6)	Adjus ted Sal ari es (col . 2 ± col . 3)	Paid Hours Related to Sal ari es in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)		
	1.00	2.00	3.00	4.00	5.00	6.00		
41.00	Medical Records & Medical Records Library	16.00	1,988,833	0	1,988,833	86,611.00	22.96	41.00
42.00	Social Service	17.00	0	275,750	275,750	8,736.00	31.56	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140213

Period:  
From 10/01/2013  
To 09/30/2014

Worksheet S-3  
Part III  
Date/Time Prepared:  
2/25/2015 8:07 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Sal ari es (from Worksheet A-6)	Adjusted Sal ari es (col . 2 ± col . 3)	Paid Hours Related to Sal ari es 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)	102,495,755	0	102,495,755	3,404,337.50	30.11	1.00
2.00	Excluded area salaries (see instructions)	6,606,139	0	6,606,139	202,550.00	32.61	2.00
3.00	Subtotal salaries (line 1 minus line 2)	95,889,616	0	95,889,616	3,201,787.50	29.95	3.00
4.00	Subtotal other wages & related costs (see inst.)	9,547,846	0	9,547,846	79,805.00	119.64	4.00
5.00	Subtotal wage-related costs (see inst.)	31,645,883	0	31,645,883	0.00	33.00	5.00
6.00	Total (sum of lines 3 thru 5)	137,083,345	0	137,083,345	3,281,592.50	41.77	6.00
7.00	Total overhead cost (see instructions)	29,524,650	-735,495	28,789,155	1,110,846.50	25.92	7.00



HOSPITAL WAGE RELATED COSTS		Provider CCN: 140213	Period: From 10/01/2013 To 09/30/2014	Worksheet S-3 Part IV Date/Time Prepared: 2/25/2015 8:07 am
				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			0 1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution			0 2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)		3,896,197	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)		0	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)		17,801,265	8.00
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		646,043	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		113,747	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)		756,332	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		2,601,598	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		7,586,945	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		69,000	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		359,802	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		33,830,929	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: 140213	Period: From 10/01/2013 To 09/30/2014	Worksheet S-3 Part V Date/Time Prepared: 2/25/2015 8:07 am
Cost Center Description			Contract Labor	Benefit Cost
			1.00	2.00
<b>PART V - Contract Labor and Benefit Cost</b>				
<b>Hospital and Hospital-Based Component Identification:</b>				
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		0	0 9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA		0	0 11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC		0	0 14.00
15.00	Hospital-Based Health Clinic FQHC		0	0 15.00
16.00	Hospital-Based-CMHC		0	0 16.00
16.10	Hospital-Based-CMHC 10		0	0 16.10
17.00	Renal Dialysis		0	0 17.00
18.00	Other		0	0 18.00

HOME HEALTH AGENCY STATISTICAL DATA		Provider CCN: 140213 Component CCN: 147452		Period: From 10/01/2013 To 09/30/2014		Worksheet S-4 Date/Time Prepared: 2/25/2015 8:07 am	
				Home Health Agency I		PPS	
				1.00			
0.00	County			WILL		0.00	
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
HOME HEALTH AGENCY STATISTICAL DATA							
1.00	Home Health Aide Hours	0	2,628	0	0	2,628	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	964.00	24.00	326.00	1,314.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES							
3.00	Administrator and Assistant Administrator(s)	40.00		7.63	0.00	7.63	3.00
4.00	Director(s) and Assistant Director(s)			0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel			0.00	0.00	0.00	5.00
6.00	Direct Nursing Service			11.48	0.00	11.48	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			0.00	77.00	77.00	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			0.00	1.80	1.80	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.00	3.60	3.60	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.08	4.90	4.98	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			1.26	0.00	1.26	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	HOMEMAKER			0.00	0.00	0.00	18.00
HOME HEALTH AGENCY CBSA CODES							
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			1			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			16974			20.00
		Full Episodes		LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		Without Outliers	With Outliers	3.00	4.00	5.00	
		1.00	2.00	3.00	4.00	5.00	
PPS ACTIVITY DATA							
21.00	Skilled Nursing Visits	7,770	723	325	546	9,364	21.00
22.00	Skilled Nursing Visit Charges	1,686,097	168,801	56,589	118,474	2,029,961	22.00
23.00	Physical Therapy Visits	4,652	127	20	255	5,054	23.00
24.00	Physical Therapy Visit Charges	1,050,422	28,677	4,516	57,579	1,141,194	24.00
25.00	Occupational Therapy Visits	1,250	45	2	74	1,371	25.00
26.00	Occupational Therapy Visit Charges	282,476	10,161	452	16,709	309,798	26.00
27.00	Speech Pathology Visits	194	40	0	4	238	27.00
28.00	Speech Pathology Visit Charges	46,492	9,586	0	959	57,037	28.00
29.00	Medical Social Service Visits	112	8	0	10	130	29.00
30.00	Medical Social Service Visit Charges	36,932	2,638	0	3,298	42,868	30.00
31.00	Home Health Aide Visits	1,199	159	3	66	1,427	31.00
32.00	Home Health Aide Visit Charges	176,553	23,413	442	9,719	210,127	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	15,177	1,102	350	955	17,584	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	3,278,972	243,276	61,999	206,738	3,790,985	35.00
36.00	Total Number of Episodes (standard/non outlier)	767		90	46	903	36.00
37.00	Total Number of Outlier Episodes		22		8	30	37.00
38.00	Total Non-Routine Medical Supply Charges	33,263	5,753	5,035	2,730	46,781	38.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 140213	Period: From 10/01/2013 To 09/30/2014	Worksheet S-10 Date/Time Prepared: 2/25/2015 8:07 am	
				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)			0.276917	1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid			25,793,000	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?			Y	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?			Y	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid			0	5.00
6.00	Medicaid charges			102,244,000	6.00
7.00	Medicaid cost (line 1 times line 6)			28,313,102	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)			2,520,102	8.00
State Children's Health Insurance Program (SCHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone SCHIP			0	9.00
10.00	Stand-alone SCHIP charges			0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)			0	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)			0	12.00
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)			0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)			0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)			0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)			0	16.00
Uncompensated care (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care			0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations			0	18.00
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)			2,520,102	19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	27,115,000	0	27,115,000	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	7,508,604	0	7,508,604	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	7,508,604	0	7,508,604	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?			N	24.00
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit			0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)			14,146,000	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)			1,022,665	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)			13,123,335	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)			3,634,075	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)			11,142,679	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			13,662,781	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140213

Period:  
From 10/01/2013  
To 09/30/2014

Worksheet A  
Date/Time Prepared:  
2/25/2015 8:07 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification (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		61,179,325	61,179,325	-23,921,420	37,257,905	1.00
2.00	00200		0	0	14,738,710	14,738,710	2.00
4.00	00400				0	34,917,123	4.00
5.00	00500	608,075	34,309,048	34,917,123	0	34,917,123	5.00
7.00	00700	14,335,066	42,457,873	56,792,939	6,590,421	63,383,360	7.00
8.00	00800	2,695,521	5,697,877	8,393,398	0	8,393,398	8.00
9.00	00900	89,278	-52,535	36,743	0	36,743	9.00
10.00	01000	2,068,128	1,131,108	3,199,236	-2	3,199,234	10.00
11.00	01100	1,763,477	2,035,143	3,798,620	-2,766,892	1,031,728	11.00
13.00	01300	0	0	0	2,766,892	2,766,892	13.00
14.00	01400	1,734,410	36,980	1,771,390	-41	1,771,349	14.00
15.00	01500	1,307,624	1,212,890	2,520,514	-1,933,990	586,524	15.00
16.00	01600	2,720,974	11,620,213	14,341,187	-9,871,724	4,469,463	16.00
17.00	01700	1,988,833	843,429	2,832,262	0	2,832,262	17.00
23.00	02300	0	0	0	275,750	275,750	23.00
		296,347	399,424	695,771	-2,021	693,750	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	19,120,152	2,509,717	21,629,869	3,379,500	25,009,369	30.00
31.00	03100	4,621,013	1,299,738	5,920,751	-230,744	5,690,007	31.00
40.00	04000	1,586,214	361,220	1,947,434	35,321	1,982,755	40.00
41.00	04100	3,219,925	618,284	3,838,209	74,343	3,912,552	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	6,700,891	1,128,124	7,829,015	-5,584,962	2,244,053	43.00
44.00	04400	0	0	0	0	0	44.00
45.00	04500	0	0	0	0	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	7,593,826	27,567,728	35,161,554	-19,603,350	15,558,204	50.00
51.00	05100	1,153,302	52,679	1,205,981	-5,321	1,200,660	51.00
52.00	05200	0	722,558	722,558	2,481,979	3,204,537	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	6,373,390	9,237,764	15,611,154	-5,444,382	10,166,772	54.00
54.01	05401	1,027,941	169,816	1,197,757	-1,540	1,196,217	54.01
57.00	05700	919,530	741,383	1,660,913	-19,316	1,641,597	57.00
58.00	05800	549,261	454,641	1,003,902	-16	1,003,886	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	3,449,226	4,477,961	7,927,187	32,843	7,960,030	60.00
60.01	06001	0	0	0	0	0	60.01
63.00	06300	131,512	1,617,980	1,749,492	0	1,749,492	63.00
65.00	06500	1,372,446	265,228	1,637,674	84,842	1,722,516	65.00
65.01	06501	172,654	135,796	308,450	110,000	418,450	65.01
66.00	06600	1,578,350	493,398	2,071,748	-6,233	2,065,515	66.00
67.00	06700	1,326,459	215,553	1,542,012	-2,814	1,539,198	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	1,022,801	105,831	1,128,632	109,934	1,238,566	69.00
70.00	07000	219,414	17,254	236,668	668,524	905,192	70.00
71.00	07100	0	0	0	12,316,871	12,316,871	71.00
72.00	07200	0	0	0	15,616,523	15,616,523	72.00
73.00	07300	0	0	0	9,842,168	9,842,168	73.00
74.00	07400	391,905	123,842	515,747	11,291	527,038	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	445,440	358,830	804,270	38,793	843,063	90.00
90.01	09001	498,978	216,535	715,513	-536	714,977	90.01
90.02	09002	851,352	701,952	1,553,304	-9,530	1,543,774	90.02
90.03	09003	671,010	545,405	1,216,415	-55,444	1,160,971	90.03
91.00	09100	5,463,868	904,886	6,368,754	323,449	6,692,203	91.00
91.01	09101	387,218	9,005	396,223	35,050	431,273	91.01
91.02	09102	323,027	5,060	328,087	-88,445	239,642	91.02
92.00	09200	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
94.00	09400	0	0	0	0	0	94.00
99.00	09900	0	0	0	0	0	99.00
99.10	09910	0	0	0	0	0	99.10
101.00	10100	1,490,201	935,505	2,425,706	15,519	2,441,225	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	10900	0	0	0	0	0	109.00
110.00	11000	0	0	0	0	0	110.00
111.00	11100	0	0	0	0	0	111.00
118.00		102,269,039	216,864,448	319,133,487	0	319,133,487	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	13,452	0	13,452	0	13,452	190.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140213

Period:  
From 10/01/2013  
To 09/30/2014

Worksheet A  
Date/Time Prepared:  
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Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
192.00	19200	0	0	0	0	0	192.00
200.00		102,282,491	216,864,448	319,146,939	0	319,146,939	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140213

Period:  
From 10/01/2013  
To 09/30/2014

Worksheet A  
Date/Time Prepared:  
2/25/2015 8:07 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	-7,894,137	29,363,768	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	14,738,710	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-54,812	34,862,311	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-18,765,796	44,617,564	5.00
7.00	00700	OPERATION OF PLANT	-1,493	8,391,905	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	36,743	8.00
9.00	00900	HOUSEKEEPING	-110	3,199,124	9.00
10.00	01000	DIETARY	0	1,031,728	10.00
11.00	01100	CAFETERIA	-2,141,029	625,863	11.00
13.00	01300	NURSING ADMINISTRATION	-500	1,770,849	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	586,524	14.00
15.00	01500	PHARMACY	-25	4,469,438	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-10,958	2,821,304	16.00
17.00	01700	SOCIAL SERVICE	0	275,750	17.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	-218,735	475,015	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	-745,767	24,263,602	30.00
31.00	03100	INTENSIVE CARE UNIT	-8,454	5,681,553	31.00
40.00	04000	SUBPROVIDER - I PF	-36,150	1,946,605	40.00
41.00	04100	SUBPROVIDER - I RF	-100,016	3,812,536	41.00
42.00	04200	SUBPROVIDER	0	0	42.00
43.00	04300	NURSERY	-3,846	2,240,207	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	-37,591	15,520,613	50.00
51.00	05100	RECOVERY ROOM	0	1,200,660	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	3,204,537	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,059,871	14,226,643	54.00
54.01	05401	ULTRASOUND	0	1,196,217	54.01
57.00	05700	CT SCAN	-34	1,641,563	57.00
58.00	05800	MRI	0	1,003,886	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	-122	7,959,908	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	-374	1,749,118	63.00
65.00	06500	RESPIRATORY THERAPY	-70,613	1,651,903	65.00
65.01	06501	SLEEP LAB	-110,000	308,450	65.01
66.00	06600	PHYSICAL THERAPY	0	2,065,515	66.00
67.00	06700	OCCUPATIONAL THERAPY	-77	1,539,121	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	-142,266	1,096,300	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	-676,149	229,043	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	12,316,871	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	15,616,523	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	9,842,168	73.00
74.00	07400	RENAL DIALYSIS	-8,426	518,612	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	-60,985	782,078	90.00
90.01	09001	HOMER GLEN LAB	0	714,977	90.01
90.02	09002	HOMER GLEN FEC	-369,904	1,173,870	90.02
90.03	09003	WOMEN'S HEALTH	0	1,160,971	90.03
91.00	09100	EMERGENCY	-325,325	6,366,878	91.00
91.01	09101	OP MENTAL HEALTH	-42,865	388,408	91.01
91.02	09102	DIABETES CENTER	-1,359	238,283	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
94.00	09400	HOME PROGRAM DIALYSIS	0	0	94.00
99.00	09900	CMHC	0	0	99.00
99.10	09910	CORF	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	2,441,225	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
109.00	10900	PANCREAS ACQUISITION	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-27,768,047	291,365,440	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13,452	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
200.00		TOTAL (SUM OF LINES 118-199)	-27,768,047	291,378,892	200.00

RECLASSIFICATIONS

Provider CCN: 140213

Period:  
From 10/01/2013  
To 09/30/2014

Worksheet A-6  
Date/Time Prepared:  
2/25/2015 8:07 am

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
<b>A - STERILE PROCESSING</b>					
1.00	ADULTS & PEDIATRICS	30.00	10,297	13,408	1.00
2.00	OPERATING ROOM	50.00	659,004	858,110	2.00
3.00	DELIVERY ROOM & LABOR ROOM	52.00	46,336	60,336	3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	5,148	6,704	4.00
5.00	CLINIC	90.00	2,942	3,831	5.00
6.00	EMERGENCY	91.00	11,768	15,323	6.00
	O		735,495	957,712	
<b>C - CAPITAL INSURANCE</b>					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	191,289	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	209,220	2.00
	O		0	400,509	
<b>D - CHARGEABLE DRUGS</b>					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	9,842,168	1.00
	O		0	9,842,168	
<b>E - MALPRACTICE INSURANCE</b>					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	8,973,490	1.00
	O		0	8,973,490	
<b>F - DEPRECIATION</b>					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	14,547,421	1.00
	O		0	14,547,421	
<b>G - PHYSICIAN FEES</b>					
1.00	ADULTS & PEDIATRICS	30.00	0	745,338	1.00
2.00	INTENSIVE CARE UNIT	31.00	0	22,000	2.00
3.00	SUBPROVIDER - IPF	40.00	0	36,150	3.00
4.00	SUBPROVIDER - IRF	41.00	0	99,999	4.00
5.00	OPERATING ROOM	50.00	0	40,000	5.00
6.00	LABORATORY	60.00	0	34,000	6.00
7.00	RESPIRATORY THERAPY	65.00	0	88,333	7.00
8.00	SLEEP LAB	65.01	0	110,000	8.00
9.00	ELECTROCARDIOLOGY	69.00	0	110,001	9.00
10.00	ELECTROENCEPHALOGRAPHY	70.00	0	676,149	10.00
11.00	RENAL DIALYSIS	74.00	0	12,600	11.00
12.00	CLINIC	90.00	0	60,985	12.00
13.00	EMERGENCY	91.00	0	365,150	13.00
14.00	OP MENTAL HEALTH	91.01	0	35,050	14.00
15.00	DIABETES CENTER	91.02	0	5,000	15.00
16.00	HOME HEALTH AGENCY	101.00	0	35,000	16.00
	O		0	2,475,755	
<b>H - LABOR AND DELIVERY</b>					
1.00	ADULTS & PEDIATRICS	30.00	2,842,840	0	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	2,723,500	0	2.00
	O		5,566,340	0	
<b>I - SOCIAL SERVICES</b>					
1.00	SOCIAL SERVICE	17.00	275,750	0	1.00
	O		275,750	0	
<b>K - CHARGEABLE SUPPLIES</b>					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	12,316,871	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	159,216	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



RECLASSIFICATIONS

Provider CCN: 140213

Period:  
From 10/01/2013  
To 09/30/2014

Worksheet A-6

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Increases						
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
27.00		0.00	0	0		27.00
28.00		0.00	0	0		28.00
29.00		0.00	0	0		29.00
30.00		0.00	0	0		30.00
				12,476,087		
L - DIABETES MANAGEMENT						
1.00	ADULTS & PEDIATRICS	30.00	91,769	1,676		1.00
			91,769	1,676		
M - DIETARY RECLASS						
1.00	CAFETERIA	11.00	1,284,506	1,482,386		1.00
			1,284,506	1,482,386		
N - IMPLANTABLE DEVICES						
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	15,616,523		1.00
2.00		0.00	0	0		2.00
			0	15,616,523		
500.00	Grand Total: Increases		7,953,860	66,773,727		500.00

RECLASSIFICATIONS

Provider CCN: 140213

Period:  
From 10/01/2013  
To 09/30/2014

Worksheet A-6  
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		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
<b>A - STERILE PROCESSING</b>							
1.00	CENTRAL SERVICES & SUPPLY	14.00	735,495	957,712	9		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
	O		735,495	957,712			
<b>C - CAPITAL INSURANCE</b>							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	400,509	9		1.00
2.00		0.00	0	0	0		2.00
	O		0	400,509			
<b>D - CHARGEABLE DRUGS</b>							
1.00	PHARMACY	15.00	0	9,842,168	0		1.00
	O		0	9,842,168			
<b>E - MALPRACTICE INSURANCE</b>							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	8,973,490	9		1.00
	O		0	8,973,490			
<b>F - DEPRECIATION</b>							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	14,547,421	9		1.00
	O		0	14,547,421			
<b>G - PHYSICIAN FEES</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	2,475,755	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
16.00		0.00	0	0	0		16.00
	O		0	2,475,755			
<b>H - LABOR AND DELIVERY</b>							
1.00	NURSERY	43.00	5,566,340	0	0		1.00
2.00		0.00	0	0	0		2.00
	O		5,566,340	0			
<b>I - SOCIAL SERVICES</b>							
1.00	ADMINISTRATIVE & GENERAL	5.00	275,750	0	0		1.00
	O		275,750	0			
<b>K - CHARGEABLE SUPPLIES</b>							
1.00	HOUSEKEEPING	9.00	0	2	0		1.00
2.00	NURSING ADMINISTRATION	13.00	0	41	0		2.00
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	240,783	0		3.00
4.00	PHARMACY	15.00	0	29,556	0		4.00
5.00	PARAMED PRGM-(SPECIFY)	23.00	0	2,021	0		5.00
6.00	ADULTS & PEDIATRICS	30.00	0	325,828	0		6.00
7.00	INTENSIVE CARE UNIT	31.00	0	252,744	0		7.00
8.00	SUBPROVIDER - IPF	40.00	0	829	0		8.00
9.00	SUBPROVIDER - IRF	41.00	0	25,656	0		9.00
10.00	NURSERY	43.00	0	18,622	0		10.00
11.00	OPERATING ROOM	50.00	0	8,430,830	0		11.00
12.00	RECOVERY ROOM	51.00	0	5,321	0		12.00
13.00	DELIVERY ROOM & LABOR ROOM	52.00	0	348,193	0		13.00
14.00	RADIOLOGY-DIAGNOSTIC	54.00	0	2,569,345	0		14.00
15.00	ULTRASOUND	54.01	0	1,540	0		15.00
16.00	CT SCAN	57.00	0	19,316	0		16.00
17.00	MRI	58.00	0	16	0		17.00
18.00	LABORATORY	60.00	0	1,157	0		18.00
19.00	WOMEN'S HEALTH	90.03	0	55,444	0		19.00
20.00	RESPIRATORY THERAPY	65.00	0	3,491	0		20.00
21.00	PHYSICAL THERAPY	66.00	0	6,233	0		21.00
22.00	OCCUPATIONAL THERAPY	67.00	0	2,814	0		22.00
23.00	ELECTROCARDIOLOGY	69.00	0	67	0		23.00
24.00	ELECTROENCEPHALOGRAPHY	70.00	0	7,625	0		24.00
25.00	RENAL DIALYSIS	74.00	0	1,309	0		25.00
26.00	CLINIC	90.00	0	28,965	0		26.00
27.00	EMERGENCY	91.00	0	68,792	0		27.00

RECLASSIFICATIONS

Provider CCN: 140213

Period:  
From 10/01/2013  
To 09/30/2014

Worksheet A-6

Date/Time Prepared:  
2/25/2015 8:07 am

Decreases							
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
28.00	HOMER GLEN LAB	90.01	0	536	0	28.00	
29.00	HOME HEALTH AGENCY	101.00	0	19,481	0	29.00	
30.00	HOMER GLEN FEC	90.02	0	9,530	0	30.00	
			0	12,476,087			
L - DIABETES MANAGEMENT							
1.00	DIABETES CENTER	91.02	91,769	1,676	0	1.00	
			91,769	1,676			
M - DIETARY RECLASS							
1.00	DIETARY	10.00	1,284,506	1,482,386	0	1.00	
			1,284,506	1,482,386			
N - IMPLANTABLE DEVICES							
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	2,886,889	0	1.00	
2.00	OPERATING ROOM	50.00	0	12,729,634	0	2.00	
			0	15,616,523			
500.00	Grand Total: Decreases		7,953,860	66,773,727		500.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140213

Period:  
From 10/01/2013  
To 09/30/2014

Worksheet A-7  
Part I  
Date/Time Prepared:  
2/25/2015 8:07 am

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	14,801,161	0	0	0	1.00
2.00	Land Improvements	13,573,986	11,500	0	11,500	2.00
3.00	Buildings and Fixtures	333,260,750	0	0	0	3.00
4.00	Building Improvements	518,385	2,090,604	0	2,090,604	4.00
5.00	Fixed Equipment	13,139,002	41,423	0	41,423	5.00
6.00	Movable Equipment	184,197,453	9,150,124	0	9,150,124	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	559,490,737	11,293,651	0	11,293,651	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	559,490,737	11,293,651	0	11,293,651	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	14,801,161	0			1.00
2.00	Land Improvements	13,585,486	0			2.00
3.00	Buildings and Fixtures	333,260,750	0			3.00
4.00	Building Improvements	2,608,989	0			4.00
5.00	Fixed Equipment	13,180,425	0			5.00
6.00	Movable Equipment	193,347,577	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	570,784,388	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	570,784,388	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140213

Period:  
From 10/01/2013  
To 09/30/2014

Worksheet A-7  
Part II  
Date/Time Prepared:  
2/25/2015 8:07 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	25,911,473	0	25,680,145	9,523,703	64,004	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	25,911,473	0	25,680,145	9,523,703	64,004	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	61,179,325				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	61,179,325				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140213

Period:  
From 10/01/2013  
To 09/30/2014

Worksheet A-7  
Part III  
Date/Time Prepared:  
2/25/2015 8:07 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	377,436,812	0	377,436,812	0.661260	0 1.00
2.00	CAP REL COSTS-MVBLE EQUIP	193,347,577	0	193,347,577	0.338740	0 2.00
3.00	Total (sum of lines 1-2)	570,784,389	0	570,784,389	1.000000	0 3.00
Cost Center Description	ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
	Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	2,004,404	0 1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	14,738,710	0 2.00
3.00	Total (sum of lines 1-2)	0	0	0	16,743,114	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	17,771,657	9,523,703	64,004	0	29,363,768 1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	14,738,710 2.00
3.00	Total (sum of lines 1-2)	17,771,657	9,523,703	64,004	0	44,102,478 3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 140213

Period:  
From 10/01/2013  
To 09/30/2014

Worksheet A-8

Date/Time Prepared:  
2/25/2015 8:07 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Wkst. A-7 Ref.	
			Cost Center	Line #		
			3.00	4.00		
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00 Investment income - other (chapter 2)		0		0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00 Television and radio service (chapter 21)		0		0.00	0	8.00
9.00 Parking lot (chapter 21)		0		0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-3,018,675			0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	3,114,454			0	12.00
13.00 Laundry and linen service		0		0.00	0	13.00
14.00 Cafeteria-employees and guests		0		0.00	0	14.00
15.00 Rental of quarters to employee and others		0		0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00 Sale of drugs to other than patients		0		0.00	0	17.00
18.00 Sale of medical records and abstracts		0		0.00	0	18.00
19.00 Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00 Vending machines		0		0.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0*** Cost Center Deleted ***	114.00		25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT			0CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			0CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00 Non-physician Anesthetist			0*** Cost Center Deleted ***	19.00		28.00
29.00 Physicians' assistant			0	0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0OCCUPATIONAL THERAPY	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)			0ADULTS & PEDIATRICS	30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0SPEECH PATHOLOGY	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00 OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 140213

Period:  
From 10/01/2013  
To 09/30/2014

Worksheet A-8

Date/Time Prepared:  
2/25/2015 8:07 am

Line #	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		Line #	Wkst. A-7 Ref.
				Cost Center	Line #		
				1.00	2.00		
33.01	1996 DSR INTEXP. ADD ON	A	14,351	CAP REL COSTS-BLDG & FIXT		1.00	9 33.01
33.02	TELEPHONE BENEFITS	B	-16,514	EMPLOYEE BENEFITS DEPARTMENT		4.00	0 33.02
33.03	PHYSICIANS	B	-548,309	ADMINISTRATIVE & GENERAL		5.00	0 33.03
38.00	CONTRIBUTIONS EXPENSE	A	-99,087	ADMINISTRATIVE & GENERAL		5.00	9 38.00
39.00	BAD DEBTS	B	1,038,671	ADMINISTRATIVE & GENERAL		5.00	0 39.00
40.00	AHA & IHA DUES-POLITICAL LOBBY	A	-47,962	ADMINISTRATIVE & GENERAL		5.00	0 40.00
41.00	OTHER REV A & G	B	-1,668,077	ADMINISTRATIVE & GENERAL		5.00	0 41.00
42.00	TELEPHONE COSTS	A	-60,441	ADMINISTRATIVE & GENERAL		5.00	0 42.00
43.00	COMMUNITY RELATIONS	A	-1,329,322	ADMINISTRATIVE & GENERAL		5.00	0 43.00
44.00	ADVERTISING ADMIN (EXPENSE ACCT# 510)	A	-5,000	ADMINISTRATIVE & GENERAL		5.00	0 44.00
45.00	OTHER REV-EMPLOYEE BENEFITS	B	-38,298	EMPLOYEE BENEFITS DEPARTMENT		4.00	0 45.00
45.01	OTHER REV-OPERATION & PLANT	B	-1,493	OPERATION OF PLANT		7.00	0 45.01
45.02	OTHER REV-CAFÉ' -EMP & GUESTS	B	-2,137,850	CAFETERIA		11.00	0 45.02
45.04	OTHER REV-VENDING MACHINES	B	-3,179	CAFETERIA		11.00	0 45.04
45.05	OTHER REV-NURSING ADMIN	B	-500	NURSING ADMINISTRATION		13.00	0 45.05
45.06	OTHER REV-PARAMED ED PROGRAM	B	-218,735	PARAMED ED PRGM-(SPECIFY)		23.00	0 45.06
45.07	OTHER REV-A & P	B	-429	ADULTS & PEDIATRICS		30.00	0 45.07
45.08	OTHER REV-PSYCH	B	-7,815	OP MENTAL HEALTH		91.01	0 45.08
45.09	OTHER REV-NURSERY	B	-3,846	NURSERY		43.00	0 45.09
45.11	OTHER REV-RADIOLOGY	B	-3,210	RADIOLOGY-DIAGNOSTIC		54.00	0 45.11
45.12	OTHER REV-LAB	B	-122	LABORATORY		60.00	0 45.12
45.13	OTHER REV - CT SCAN	B	-34	CT SCAN		57.00	0 45.13
45.15	OTHER REV-CARDIAC CATH	B	-32,265	ELECTROCARDIOLOGY		69.00	0 45.15
45.16	OTHER REV-ER	B	-1,153	EMERGENCY		91.00	0 45.16
45.19	OTHER REV-DIABETES	B	-1,300	DIABETES CENTER		91.02	0 45.19
45.20	INVESTMENT INCOME	B	-7,908,488	CAP REL COSTS-BLDG & FIXT		1.00	11 45.20
45.22	WELLNESS PROGRAM EXPENSES	A	-348	ADMINISTRATIVE & GENERAL		5.00	0 45.22
45.24	OTHER REV-MED REC	B	-10,958	MEDICAL RECORDS & LIBRARY		16.00	0 45.24
45.25	OTHER REV-OPER ROOM	B	-91	OPERATING ROOM		50.00	0 45.25
45.27	OTHER REV-OCCUPATIONAL THERAPY	B	-77	OCCUPATIONAL THERAPY		67.00	0 45.27
45.32	OTHER REV-ENVIRONMENTAL SERVICES	B	-110	HOUSEKEEPING		9.00	0 45.32
45.34	ADMINISTRATIVE MISC. EXPENSE	A	-146,957	ADMINISTRATIVE & GENERAL		5.00	0 45.34
45.35	OTHER REV-PHARMACY	B	-25	PHARMACY		15.00	0 45.35
46.00	OTHER REV-REHAB	B	-17	SUBPROVIDER - IRF		41.00	0 46.00
46.01	OTHER REV-BLOOD	B	-374	BLOOD STORING, PROCESSING & TRANS.		63.00	0 46.01
46.03	OTHER REV-HOMER FEC	B	-369,904	HOMER GLEN FEC		90.02	0 46.03
46.05	PROVIDER TAX ASSESSMENT IN A&G	A	-14,254,558	ADMINISTRATIVE & GENERAL		5.00	0 46.05
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-27,768,047				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: 140213

Period:  
From 10/01/2013  
To 09/30/2014

Worksheet A-8-1

Date/Time Prepared:  
2/25/2015 8:07 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 HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	MANAGEMENT FEE	7,087,929	8,036,556 1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	JOINT VENTURE OPERATING EXPE	4,063,081	0 2.00
3.00	0.00			0	0 3.00
4.00	0.00			0	0 4.00
4.01	0.00			0	0 4.01
4.02	0.00			0	0 4.02
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			11,151,010	8,036,556 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	G	SILVER CROSS HO	100.00	SILVER CROSS HO	100.00	6.00
7.00	C	UCMS/SCH ONC JV	60.00	UCMS/SCH ONC JV	60.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify: FINANCIAL					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: 140213

Period:  
From 10/01/2013  
To 09/30/2014

Worksheet A-8-1

Date/Time Prepared:  
2/25/2015 8:07 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	-948,627	0		1.00
2.00	4,063,081	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
4.01	0	0		4.01
4.02	0	0		4.02
5.00	3,114,454			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	HOME OFFICE		6.00
7.00	RADIOLOGY ONCOL		7.00
8.00			8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 140213

Period:  
From 10/01/2013  
To 09/30/2014

Worksheet A-8-2

Date/Time Prepared:  
2/25/2015 8:07 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	695,779	695,779	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	745,338	745,338	0	0	0	2.00
3.00	31.00	INTENSIVE CARE UNIT	22,000	0	22,000	177,200	159	3.00
4.00	40.00	SUBPROVIDER - IPF	36,150	36,150	0	154,100	0	4.00
5.00	41.00	SUBPROVIDER - IRF	99,999	99,999	0	154,100	0	5.00
6.00	50.00	OPERATING ROOM	40,000	35,000	5,000	208,000	25	6.00
7.00	65.00	RESPIRATORY THERAPY	88,333	70,001	18,332	177,200	208	7.00
8.00	66.00	PHYSICAL THERAPY	0	0	0	177,200	0	8.00
9.00	69.00	ELECTROCARDIOLOGY	110,001	110,001	0	177,200	0	9.00
10.00	70.00	ELECTROENCEPHALOGRAPHY	676,149	676,149	0	177,200	0	10.00
11.00	74.00	RENAL DIALYSIS	12,600	0	12,600	177,200	49	11.00
12.00	90.00	CLINIC	60,985	60,985	0	177,200	0	12.00
13.00	91.00	EMERGENCY	365,150	300,150	65,000	177,200	481	13.00
14.00	65.01	SLEEP LAB	110,000	110,000	0	0	0	14.00
15.00	60.00	LABORATORY	34,000	0	34,000	215,700	460	15.00
16.00	91.01	OP MENTAL HEALTH	35,050	35,050	0	0	0	16.00
17.00	91.02	DIABETES CENTER	5,000	0	5,000	177,200	58	17.00
200.00			3,136,534	2,974,602	161,932		1,440	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	31.00	INTENSIVE CARE UNIT	13,546	677	0	0	0	3.00
4.00	40.00	SUBPROVIDER - IPF	0	0	0	0	0	4.00
5.00	41.00	SUBPROVIDER - IRF	0	0	0	0	0	5.00
6.00	50.00	OPERATING ROOM	2,500	125	0	0	0	6.00
7.00	65.00	RESPIRATORY THERAPY	17,720	886	0	0	0	7.00
8.00	66.00	PHYSICAL THERAPY	0	0	0	0	0	8.00
9.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	9.00
10.00	70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	10.00
11.00	74.00	RENAL DIALYSIS	4,174	209	0	0	0	11.00
12.00	90.00	CLINIC	0	0	0	0	0	12.00
13.00	91.00	EMERGENCY	40,978	2,049	0	0	0	13.00
14.00	65.01	SLEEP LAB	0	0	0	0	0	14.00
15.00	60.00	LABORATORY	47,703	2,385	0	0	0	15.00
16.00	91.01	OP MENTAL HEALTH	0	0	0	0	0	16.00
17.00	91.02	DIABETES CENTER	4,941	247	0	0	0	17.00
200.00			131,562	6,578	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	695,779		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	745,338		2.00
3.00	31.00	INTENSIVE CARE UNIT	0	13,546	8,454	8,454		3.00
4.00	40.00	SUBPROVIDER - IPF	0	0	0	36,150		4.00
5.00	41.00	SUBPROVIDER - IRF	0	0	0	99,999		5.00
6.00	50.00	OPERATING ROOM	0	2,500	2,500	37,500		6.00
7.00	65.00	RESPIRATORY THERAPY	0	17,720	612	70,613		7.00
8.00	66.00	PHYSICAL THERAPY	0	0	0	0		8.00
9.00	69.00	ELECTROCARDIOLOGY	0	0	0	110,001		9.00
10.00	70.00	ELECTROENCEPHALOGRAPHY	0	0	0	676,149		10.00
11.00	74.00	RENAL DIALYSIS	0	4,174	8,426	8,426		11.00
12.00	90.00	CLINIC	0	0	0	60,985		12.00
13.00	91.00	EMERGENCY	0	40,978	24,022	324,172		13.00
14.00	65.01	SLEEP LAB	0	0	0	110,000		14.00
15.00	60.00	LABORATORY	0	47,703	0	0		15.00
16.00	91.01	OP MENTAL HEALTH	0	0	0	35,050		16.00
17.00	91.02	DIABETES CENTER	0	4,941	59	59		17.00
200.00			0	131,562	44,073	3,018,675		200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140213

Period:  
From 10/01/2013  
To 09/30/2014

Worksheet B  
Part I  
Date/Time Prepared:  
2/25/2015 8:07 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst Allocation)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	29,363,768	29,363,768			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	14,738,710		14,738,710		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	34,862,311	108,807	4,392	34,975,510	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	44,617,564	6,749,188	6,844,374	4,836,334	63,047,460
7.00 00700	OPERATION OF PLANT	8,391,905	361,287	54,236	927,246	9,734,674
8.00 00800	LAUNDRY & LINEN SERVICE	36,743	124,273	0	30,711	191,727
9.00 00900	HOUSEKEEPING	3,199,124	308,097	44,715	711,426	4,263,362
10.00 01000	DIETARY	1,031,728	1,224,465	13,517	164,764	2,434,474
11.00 01100	CAFETERIA	625,863	0	36,251	441,864	1,103,978
13.00 01300	NURSING ADMINISTRATION	1,770,849	154,991	52,895	596,628	2,575,363
14.00 01400	CENTRAL SERVICES & SUPPLY	586,524	988,044	210,912	196,810	1,982,290
15.00 01500	PHARMACY	4,469,438	407,850	0	936,001	5,813,289
16.00 01600	MEDICAL RECORDS & LIBRARY	2,821,304	57,718	7,756	684,149	3,570,927
17.00 01700	SOCIAL SERVICE	275,750	0	0	94,857	370,607
23.00 02300	PARAMED PRGM-(SPECIFY)	475,015	45,161	43,236	101,942	665,354
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	24,263,602	6,350,500	490,677	7,590,289	38,695,068
31.00 03100	INTENSIVE CARE UNIT	5,681,553	914,967	222,882	1,589,605	8,409,007
40.00 04000	SUBPROVIDER - I/PF	1,946,605	597,062	20,406	545,650	3,109,723
41.00 04100	SUBPROVIDER - I/RF	3,812,536	1,086,880	23,320	1,107,638	6,030,374
42.00 04200	SUBPROVIDER	0	0	0	0	0
43.00 04300	NURSERY	2,240,207	2,453,403	156,899	390,280	5,240,789
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	0
45.00 04500	NURSING FACILITY	0	0	0	0	0
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	15,520,613	2,958,634	1,921,549	2,838,932	23,239,728
51.00 05100	RECOVERY ROOM	1,200,660	233,727	33,245	396,730	1,864,362
52.00 05200	DELIVERY ROOM & LABOR ROOM	3,204,537	0	286,788	952,810	4,444,135
53.00 05300	ANESTHESIOLOGY	0	0	0	0	0
54.00 05400	RADIOLOGY-DIAGNOSTIC	14,226,643	1,321,092	1,864,700	2,194,185	19,606,620
54.01 05401	ULTRASOUND	1,196,217	161,782	175,828	353,607	1,887,434
57.00 05700	CT SCAN	1,641,563	145,129	414,535	316,314	2,517,541
58.00 05800	MRI	1,003,886	187,111	270,944	188,943	1,650,884
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00 06000	LABORATORY	7,959,908	32,281	44,554	1,186,516	9,223,259
60.01 06001	BLOOD LABORATORY	0	0	0	0	0
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	1,749,118	0	5,372	45,239	1,799,729
65.00 06500	RESPIRATORY THERAPY	1,651,903	105,896	53,152	472,115	2,283,066
65.01 06501	SLEEP LAB	308,450	0	27,857	59,392	395,699
66.00 06600	PHYSICAL THERAPY	2,065,515	13,419	34,400	542,945	2,656,279
67.00 06700	OCCUPATIONAL THERAPY	1,539,121	0	2,614	456,295	1,998,030
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00 06900	ELECTROCARDIOLOGY	1,096,300	78,466	77,137	351,838	1,603,741
70.00 07000	ELECTROENCEPHALOGRAPHY	229,043	56,047	8,736	75,477	369,303
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	12,316,871	0	0	0	12,316,871
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	15,616,523	0	0	0	15,616,523
73.00 07300	DRUGS CHARGED TO PATIENTS	9,842,168	0	567,886	0	10,410,054
74.00 07400	RENAL DIALYSIS	518,612	156,069	31,924	134,813	841,418
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	0
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00 09000	CLINIC	782,078	0	2,693	154,241	939,012
90.01 09001	HOMER GLEN LAB	714,977	0	2,428	171,646	889,051
90.02 09002	HOMER GLEN FEC	1,173,870	0	36,474	292,861	1,503,205
90.03 09003	WOMEN'S HEALTH	1,160,971	0	271,241	230,824	1,663,036
91.00 09100	EMERGENCY	6,366,878	1,718,648	374,689	1,883,591	10,343,806
91.01 09101	OP MENTAL HEALTH	388,408	165,285	1,754	133,201	688,648
91.02 09102	DIABETES CENTER	238,283	0	457	79,552	318,292
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0
<b>OTHER REIMBURSABLE COST CENTERS</b>						
94.00 09400	HOME PROGRAM DIALYSIS	0	0	0	0	0
99.00 09900	CMHC	0	0	0	0	0
99.10 09910	CORF	0	0	0	0	0
101.00 10100	HOME HEALTH AGENCY	2,441,225	0	1,285	512,622	2,955,132
<b>SPECIAL PURPOSE COST CENTERS</b>						
109.00 10900	PANCREAS ACQUISITION	0	0	0	0	0
110.00 11000	INTESTINAL ACQUISITION	0	0	0	0	0
111.00 11100	ISLET ACQUISITION	0	0	0	0	0

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140213

Period:  
From 10/01/2013  
To 09/30/2014

Worksheet B  
Part I  
Date/Time Prepared:  
2/25/2015 8:07 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	2.00	4.00	4A		
118.00	SUBTOTALS (SUM OF LINES 1-117)	291,365,440	29,266,279	14,738,710	34,970,883	291,263,324	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	13,452	97,489	0	4,627	115,568	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00	Cross Foot Adjustments					0	200.00
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	291,378,892	29,363,768	14,738,710	34,975,510	291,378,892	202.00

COST ALLOCATION - GENERAL SERVICE COSTS				Provider CCN: 140213	Period: From 10/01/2013 To 09/30/2014	Worksheet B Part I Date/Time Prepared: 2/25/2015 8:07 am		
Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
<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	63,047,460					5.00
7.00	00700	OPERATION OF PLANT	2,687,967	12,422,641				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	52,940	69,715	314,382			8.00
9.00	00900	HOUSEKEEPING	1,177,212	172,836	0	5,613,410		9.00
10.00	01000	DIETARY	672,214	686,902	3,609	316,571	4,113,770	10.00
11.00	01100	CAFETERIA	304,834	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	711,117	86,947	0	40,071	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	547,356	554,274	793	255,447	0	14.00
15.00	01500	PHARMACY	1,605,183	228,796	0	105,445	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	986,015	32,378	0	14,922	0	16.00
17.00	01700	SOCIAL SERVICE	102,333	0	0	0	0	17.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	183,720	25,334	11,504	11,676	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	10,684,499	3,562,512	119,192	1,641,848	2,750,621	30.00
31.00	03100	INTENSIVE CARE UNIT	2,321,920	513,279	15,627	236,554	704,402	31.00
40.00	04000	SUBPROVIDER - I/PF	858,666	334,941	0	154,363	227,849	40.00
41.00	04100	SUBPROVIDER - I/RF	1,665,125	609,719	16,694	281,000	430,898	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	1,447,102	1,376,313	0	634,298	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	6,417,023	1,659,738	47,605	764,920	0	50.00
51.00	05100	RECOVERY ROOM	514,793	131,116	3,133	60,427	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,227,128	0	20,225	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,413,839	741,108	13,282	341,553	0	54.00
54.01	05401	ULTRASOUND	521,164	90,757	971	41,827	0	54.01
57.00	05700	CT SCAN	695,151	81,415	971	37,521	0	57.00
58.00	05800	MRI	455,847	104,966	3,324	48,375	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	2,546,754	18,109	0	8,346	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	496,947	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	630,407	59,406	0	27,378	0	65.00
65.01	06501	SLEEP LAB	109,262	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	733,460	7,528	3,479	3,469	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	551,702	0	3,091	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	442,830	44,018	212	20,286	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	101,973	31,441	0	14,490	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,400,971	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,312,081	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,874,455	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	232,335	87,552	0	40,350	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	259,283	0	129	0	0	90.00
90.01	09001	HOMER GLEN LAB	245,487	0	1,050	0	0	90.01
90.02	09002	HOMER GLEN FEC	415,069	0	5,739	0	0	90.02
90.03	09003	WOMEN'S HEALTH	459,202	0	11,016	0	0	90.03
91.00	09100	EMERGENCY	2,856,163	964,129	32,736	444,336	0	91.00
91.01	09101	OP MENTAL HEALTH	190,152	92,722	0	42,732	0	91.01
91.02	09102	DIABETES CENTER	87,888	0	0	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	815,980	0	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	63,015,549	12,367,951	314,382	5,588,205	4,113,770	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	31,911	54,690	0	25,205	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 140213			Period: From 10/01/2013 To 09/30/2014		Worksheet B Part I Date/Time Prepared: 2/25/2015 8:07 am	
Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY		
		5.00	7.00	8.00	9.00	10.00		
201.00	Negative Cost Centers	0	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	63,047,460	12,422,641	314,382	5,613,410	4,113,770	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 140213		Period: From 10/01/2013 To 09/30/2014		Worksheet B Part I Date/Time Prepared: 2/25/2015 8:07 am	
Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
<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
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	1,408,812					11.00
13.00	01300		3,443,529				13.00
14.00	01400	20,420	0	3,360,580			14.00
15.00	01500	34,848	0	38,700	7,826,261		15.00
16.00	01600	47,984	0	2,784	0	4,655,010	16.00
17.00	01700	4,840	0	0	0	0	17.00
23.00	02300	29,662	0	21,749	26,388	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	399,076	2,251,163	214,316	2,330	1,842,217	30.00
31.00	03100	67,436	380,408	70,566	1,777	567,057	31.00
40.00	04000	28,325	0	3,840	0	147,985	40.00
41.00	04100	54,034	304,806	13,010	1,007	143,918	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	17,816	100,479	28,296	0	198,948	43.00
44.00	04400	0	0	0	0	0	44.00
45.00	04500	0	0	0	0	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	139,816	0	335,403	0	0	50.00
51.00	05100	13,886	0	5,007	0	0	51.00
52.00	05200	44,170	249,165	38,729	0	0	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	113,105	0	103,311	17,729	0	54.00
54.01	05401	14,969	0	12,186	0	0	54.01
57.00	05700	14,266	0	33,660	0	0	57.00
58.00	05800	7,122	0	6,872	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	75,192	0	400,525	0	0	60.00
60.01	06001	0	0	0	0	0	60.01
63.00	06300	2,339	0	24,323	0	0	63.00
65.00	06500	26,078	0	25,143	0	0	65.00
65.01	06501	3,849	0	1,748	0	0	65.01
66.00	06600	23,969	0	2,626	0	428,523	66.00
67.00	06700	22,160	0	3,692	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	17,297	0	4,456	0	0	69.00
70.00	07000	3,964	0	550	0	99,534	70.00
71.00	07100	0	0	1,815,425	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	7,775,339	0	73.00
74.00	07400	4,506	25,417	12,414	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	11,063	0	5,161	0	18,782	90.00
90.01	09001	8,942	0	20,582	0	0	90.01
90.02	09002	13,010	0	10,117	0	0	90.02
90.03	09003	11,339	0	9,504	0	0	90.03
91.00	09100	95,301	0	87,775	1,691	1,208,046	91.00
91.01	09101	7,179	0	1,027	0	0	91.01
91.02	09102	0	0	560	0	0	91.02
92.00	09200	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
94.00	09400	0	0	0	0	0	94.00
99.00	09900	0	0	0	0	0	99.00
99.10	09910	0	0	0	0	0	99.10
101.00	10100	0	132,091	6,523	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	10900	0	0	0	0	0	109.00
110.00	11000	0	0	0	0	0	110.00
111.00	11100	0	0	0	0	0	111.00
118.00		1,407,994	3,443,529	3,360,580	7,826,261	4,655,010	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	818	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00



COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140213

Period:  
From 10/01/2013  
To 09/30/2014

Worksheet B  
Part I  
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Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	1,408,812	3,443,529	3,360,580	7,826,261	4,655,010	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140213

Period:  
From 10/01/2013  
To 09/30/2014

Worksheet B  
Part I  
Date/Time Prepared:  
2/25/2015 8:07 am

Cost Center Description			SOCIAL SERVICE	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	23.00	24.00	25.00	26.00	
<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
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	477,780					17.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	975,387				23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	415,004	0	62,577,846	0	62,577,846	30.00
31.00	03100	INTENSIVE CARE UNIT	25,450	70,657	13,384,140	0	13,384,140	31.00
40.00	04000	SUBPROVIDER - I/PF	0	20,898	4,886,590	0	4,886,590	40.00
41.00	04100	SUBPROVIDER - I/RF	0	0	9,550,585	0	9,550,585	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	9,044,041	0	9,044,041	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	44,409	32,648,642	0	32,648,642	50.00
51.00	05100	RECOVERY ROOM	0	0	2,592,724	0	2,592,724	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	36,821	6,060,373	0	6,060,373	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	26,350,547	0	26,350,547	54.00
54.01	05401	ULTRASOUND	0	0	2,569,308	0	2,569,308	54.01
57.00	05700	CT SCAN	0	0	3,380,525	0	3,380,525	57.00
58.00	05800	MRI	0	0	2,277,390	0	2,277,390	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	12,272,185	0	12,272,185	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	2,323,338	0	2,323,338	63.00
65.00	06500	RESPIRATORY THERAPY	0	34,831	3,086,309	0	3,086,309	65.00
65.01	06501	SLEEP LAB	0	0	510,558	0	510,558	65.01
66.00	06600	PHYSICAL THERAPY	0	0	3,859,333	0	3,859,333	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	2,578,675	0	2,578,675	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	31,845	2,164,685	0	2,164,685	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	621,255	0	621,255	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	17,533,267	0	17,533,267	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	19,928,604	0	19,928,604	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	21,059,848	0	21,059,848	73.00
74.00	07400	RENAL DIALYSIS	0	0	1,243,992	0	1,243,992	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	5,938	0	1,239,368	0	1,239,368	90.00
90.01	09001	HOMER GLEN LAB	0	0	1,165,112	0	1,165,112	90.01
90.02	09002	HOMER GLEN FEC	0	0	1,947,140	0	1,947,140	90.02
90.03	09003	WOMEN'S HEALTH	0	0	2,154,097	0	2,154,097	90.03
91.00	09100	EMERGENCY	31,388	735,926	16,801,297	0	16,801,297	91.00
91.01	09101	OP MENTAL HEALTH	0	0	1,022,460	0	1,022,460	91.01
91.02	09102	DIABETES CENTER	0	0	406,740	0	406,740	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	3,909,726	0	3,909,726	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	477,780	975,387	291,150,700	0	291,150,700	118.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140213

Period:  
From 10/01/2013  
To 09/30/2014

Worksheet B  
Part I  
Date/Time Prepared:  
2/25/2015 8:07 am

Cost Center Description			SOCIAL SERVICE	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	23.00	24.00	25.00	26.00	
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	228,192	0	228,192	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	477,780	975,387	291,378,892	0	291,378,892	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 140213		Period: From 10/01/2013 To 09/30/2014		Worksheet B Part II Date/Time Prepared: 2/25/2015 8:07 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	4.00			
<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	0	108,807	4,392	113,199	4.00	
5.00	00500	ADMINISTRATIVE & GENERAL	0	6,749,188	6,844,374	13,593,562	5.00	
7.00	00700	OPERATION OF PLANT	0	361,287	54,236	415,523	7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	0	124,273	0	124,273	8.00	
9.00	00900	HOUSEKEEPING	0	308,097	44,715	352,812	9.00	
10.00	01000	DIETARY	0	1,224,465	13,517	1,237,982	10.00	
11.00	01100	CAFETERIA	0	0	36,251	36,251	11.00	
13.00	01300	NURSING ADMINISTRATION	0	154,991	52,895	207,886	13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY	0	988,044	210,912	1,198,956	14.00	
15.00	01500	PHARMACY	0	407,850	0	407,850	15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	0	57,718	7,756	65,474	16.00	
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00	
23.00	02300	PARAMED PRGM-(SPECIFY)	0	45,161	43,236	88,397	23.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	0	6,350,500	490,677	6,841,177	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	914,967	222,882	1,137,849	31.00	
40.00	04000	SUBPROVIDER - IPF	0	597,062	20,406	617,468	40.00	
41.00	04100	SUBPROVIDER - IRF	0	1,086,880	23,320	1,110,200	41.00	
42.00	04200	SUBPROVIDER	0	0	0	0	42.00	
43.00	04300	NURSERY	0	2,453,403	156,899	2,610,302	43.00	
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00	
45.00	04500	NURSING FACILITY	0	0	0	0	45.00	
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	2,958,634	1,921,549	4,880,183	50.00	
51.00	05100	RECOVERY ROOM	0	233,727	33,245	266,972	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	286,788	286,788	52.00	
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,321,092	1,864,700	3,185,792	54.00	
54.01	05401	ULTRASOUND	0	161,782	175,828	337,610	54.01	
57.00	05700	CT SCAN	0	145,129	414,535	559,664	57.00	
58.00	05800	MRI	0	187,111	270,944	458,055	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00	
60.00	06000	LABORATORY	0	32,281	44,554	76,835	60.00	
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01	
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	5,372	5,372	63.00	
65.00	06500	RESPIRATORY THERAPY	0	105,896	53,152	159,048	65.00	
65.01	06501	SLEEP LAB	0	0	27,857	27,857	65.01	
66.00	06600	PHYSICAL THERAPY	0	13,419	34,400	47,819	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0	0	2,614	2,614	67.00	
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	0	78,466	77,137	155,603	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0	56,047	8,736	64,783	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	567,886	567,886	73.00	
74.00	07400	RENAL DIALYSIS	0	156,069	31,924	187,993	74.00	
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00	
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00	
90.00	09000	CLINIC	0	0	2,693	2,693	90.00	
90.01	09001	HOMER GLEN LAB	0	0	2,428	2,428	90.01	
90.02	09002	HOMER GLEN FEC	0	0	36,474	36,474	90.02	
90.03	09003	WOMEN'S HEALTH	0	0	271,241	271,241	90.03	
91.00	09100	EMERGENCY	0	1,718,648	374,689	2,093,337	91.00	
91.01	09101	OP MENTAL HEALTH	0	165,285	1,754	167,039	91.01	
91.02	09102	DIABETES CENTER	0	0	457	457	91.02	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00	
<b>OTHER REIMBURSABLE COST CENTERS</b>								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	94.00	
99.00	09900	CMHC	0	0	0	0	99.00	
99.10	09910	CORF	0	0	0	0	99.10	
101.00	10100	HOME HEALTH AGENCY	0	0	1,285	1,285	101.00	
<b>SPECIAL PURPOSE COST CENTERS</b>								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	109.00	
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	110.00	
111.00	11100	ISLET ACQUISITION	0	0	0	0	111.00	
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	29,266,279	14,738,710	44,004,989	118.00	

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140213	Period: From 10/01/2013 To 09/30/2014	Worksheet B Part II Date/Time Prepared: 2/25/2015 8:07 am
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Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT			
		BLDG & FIXT	MVBLE EQUIP					
		0	1.00				2.00	2A
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	97,489	0	97,489	15	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	0	29,363,768	14,738,710	44,102,478	113,199	202.00

ALLOCATION OF CAPITAL RELATED COSTS				Provider CCN: 140213	Period: From 10/01/2013 To 09/30/2014	Worksheet B Part II Date/Time Prepared: 2/25/2015 8:07 am		
Cost Center Description				ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY
				5.00	7.00	8.00	9.00	10.00
<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	13,609,210					5.00
7.00	00700	OPERATION OF PLANT	580,216	998,739				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	11,428	5,605	141,405			8.00
9.00	00900	HOUSEKEEPING	254,109	13,895	0	623,118		9.00
10.00	01000	DIETARY	145,102	55,225	1,623	35,141	1,475,606	10.00
11.00	01100	CAFETERIA	65,800	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	153,499	6,990	0	4,448	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	118,150	44,562	357	28,356	0	14.00
15.00	01500	PHARMACY	346,489	18,394	0	11,705	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	212,838	2,603	0	1,656	0	16.00
17.00	01700	SOCIAL SERVICE	22,089	0	0	0	0	17.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	39,657	2,037	5,174	1,296	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	2,306,313	286,414	53,612	182,255	986,646	30.00
31.00	03100	INTENSIVE CARE UNIT	501,202	41,266	7,029	26,259	252,668	31.00
40.00	04000	SUBPROVIDER - I/PF	185,349	26,928	0	17,135	81,729	40.00
41.00	04100	SUBPROVIDER - I/RF	359,428	49,019	7,509	31,192	154,563	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	312,367	110,651	0	70,410	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	1,385,158	133,437	21,412	84,910	0	50.00
51.00	05100	RECOVERY ROOM	111,122	10,541	1,409	6,708	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	264,884	0	9,097	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,168,613	59,583	5,974	37,914	0	54.00
54.01	05401	ULTRASOUND	112,497	7,297	437	4,643	0	54.01
57.00	05700	CT SCAN	150,053	6,545	437	4,165	0	57.00
58.00	05800	MRI	98,398	8,439	1,495	5,370	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	549,734	1,456	0	926	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	107,269	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	136,078	4,776	0	3,039	0	65.00
65.01	06501	SLEEP LAB	23,585	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	158,322	605	1,565	385	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	119,089	0	1,390	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	95,588	3,539	95	2,252	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	22,012	2,528	0	1,608	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	734,122	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	930,792	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	620,470	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	50,151	7,039	0	4,479	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	55,968	0	58	0	0	90.00
90.01	09001	HOMER GLEN LAB	52,990	0	472	0	0	90.01
90.02	09002	HOMER GLEN FEC	89,596	0	2,581	0	0	90.02
90.03	09003	WOMEN'S HEALTH	99,122	0	4,955	0	0	90.03
91.00	09100	EMERGENCY	616,522	77,513	14,724	49,324	0	91.00
91.01	09101	OP MENTAL HEALTH	41,045	7,455	0	4,744	0	91.01
91.02	09102	DIABETES CENTER	18,971	0	0	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	176,135	0	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	13,602,322	994,342	141,405	620,320	1,475,606	118.00
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	6,888	4,397	0	2,798	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140213			Period: From 10/01/2013 To 09/30/2014		Worksheet B Part II Date/Time Prepared: 2/25/2015 8:07 am	
Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY		
201.00	Negative Cost Centers	5.00	7.00	8.00	9.00	10.00	0	201.00
202.00	TOTAL (sum lines 118-201)	13,609,210	998,739	141,405	623,118	1,475,606	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140213		Period: From 10/01/2013 To 09/30/2014		Worksheet B Part II Date/Time Prepared: 2/25/2015 8:07 am	
Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
<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
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	103,481					11.00
13.00	01300		376,959				13.00
14.00	01400	2,206		1,392,518			14.00
15.00	01500	1,500	0	16,036	806,062		15.00
16.00	01600	2,560	0	1,154	0	289,464	16.00
17.00	01700	3,525	0	0	0	0	17.00
23.00	02300	356	0	0	0	0	23.00
		2,179	0	9,012	2,718	0	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	29,308	246,432	88,806	240	114,557	30.00
31.00	03100	4,953	41,643	29,240	183	35,261	31.00
40.00	04000	2,081	0	1,591	0	9,202	40.00
41.00	04100	3,969	33,367	5,391	104	8,949	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	1,309	10,999	11,725	0	12,371	43.00
44.00	04400	0	0	0	0	0	44.00
45.00	04500	0	0	0	0	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	10,270	0	138,980	0	0	50.00
51.00	05100	1,020	0	2,075	0	0	51.00
52.00	05200	3,244	27,276	16,048	0	0	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	8,308	0	42,809	1,826	0	54.00
54.01	05401	1,100	0	5,049	0	0	54.01
57.00	05700	1,048	0	13,948	0	0	57.00
58.00	05800	523	0	2,848	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	5,523	0	165,965	0	0	60.00
60.01	06001	0	0	0	0	0	60.01
63.00	06300	172	0	10,079	0	0	63.00
65.00	06500	1,916	0	10,418	0	0	65.00
65.01	06501	283	0	724	0	0	65.01
66.00	06600	1,761	0	1,088	0	26,647	66.00
67.00	06700	1,628	0	1,530	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	1,271	0	1,847	0	0	69.00
70.00	07000	291	0	228	0	6,189	70.00
71.00	07100	0	0	752,253	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	800,817	0	73.00
74.00	07400	331	2,782	5,144	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	813	0	2,139	0	1,168	90.00
90.01	09001	657	0	8,529	0	0	90.01
90.02	09002	956	0	4,192	0	0	90.02
90.03	09003	833	0	3,938	0	0	90.03
91.00	09100	7,000	0	36,371	174	75,120	91.00
91.01	09101	527	0	426	0	0	91.01
91.02	09102	0	0	232	0	0	91.02
92.00	09200	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
94.00	09400	0	0	0	0	0	94.00
99.00	09900	0	0	0	0	0	99.00
99.10	09910	0	0	0	0	0	99.10
101.00	10100	0	14,460	2,703	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	10900	0	0	0	0	0	109.00
110.00	11000	0	0	0	0	0	110.00
111.00	11100	0	0	0	0	0	111.00
118.00		103,421	376,959	1,392,518	806,062	289,464	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	60	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00



ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140213			Period: From 10/01/2013 To 09/30/2014		Worksheet B Part II Date/Time Prepared: 2/25/2015 8:07 am	
Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY		
		11.00	13.00	14.00	15.00	16.00		
200.00	Cross Foot Adjustments							200.00
201.00	Negative Cost Centers	0	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	103,481	376,959	1,392,518	806,062	289,464		202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140213

Period:  
From 10/01/2013  
To 09/30/2014

Worksheet B  
Part II  
Date/Time Prepared:  
2/25/2015 8:07 am

Cost Center Description		SOCIAL SERVICE	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		17.00	23.00	24.00	25.00	26.00	
<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
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
13.00	01300						13.00
14.00	01400						14.00
15.00	01500						15.00
16.00	01600						16.00
17.00	01700	22,752					17.00
23.00	02300		150,800				23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	19,762		11,180,118	0	11,180,118	30.00
31.00	03100	1,212		2,083,908	0	2,083,908	31.00
40.00	04000	0		943,248	0	943,248	40.00
41.00	04100	0		1,767,275	0	1,767,275	41.00
42.00	04200	0		0	0	0	42.00
43.00	04300	0		3,141,397	0	3,141,397	43.00
44.00	04400	0		0	0	0	44.00
45.00	04500	0		0	0	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	0		6,663,535	0	6,663,535	50.00
51.00	05100	0		401,131	0	401,131	51.00
52.00	05200	0		610,420	0	610,420	52.00
53.00	05300	0		0	0	0	53.00
54.00	05400	0		4,517,918	0	4,517,918	54.00
54.01	05401	0		469,777	0	469,777	54.01
57.00	05700	0		736,883	0	736,883	57.00
58.00	05800	0		575,739	0	575,739	58.00
59.00	05900	0		0	0	0	59.00
60.00	06000	0		804,278	0	804,278	60.00
60.01	06001	0		0	0	0	60.01
63.00	06300	0		123,038	0	123,038	63.00
65.00	06500	0		316,803	0	316,803	65.00
65.01	06501	0		52,641	0	52,641	65.01
66.00	06600	0		239,949	0	239,949	66.00
67.00	06700	0		127,727	0	127,727	67.00
68.00	06800	0		0	0	0	68.00
69.00	06900	0		261,333	0	261,333	69.00
70.00	07000	0		97,883	0	97,883	70.00
71.00	07100	0		1,486,375	0	1,486,375	71.00
72.00	07200	0		930,792	0	930,792	72.00
73.00	07300	0		1,989,173	0	1,989,173	73.00
74.00	07400	0		258,355	0	258,355	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	0		0	0	0	88.00
89.00	08900	0		0	0	0	89.00
90.00	09000	283		63,621	0	63,621	90.00
90.01	09001	0		65,631	0	65,631	90.01
90.02	09002	0		134,747	0	134,747	90.02
90.03	09003	0		380,836	0	380,836	90.03
91.00	09100	1,495		2,977,674	0	2,977,674	91.00
91.01	09101	0		221,667	0	221,667	91.01
91.02	09102	0		19,917	0	19,917	91.02
92.00	09200	0		0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
94.00	09400	0		0	0	0	94.00
99.00	09900	0		0	0	0	99.00
99.10	09910	0		0	0	0	99.10
101.00	10100	0		196,242	0	196,242	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	10900	0		0	0	0	109.00
110.00	11000	0		0	0	0	110.00
111.00	11100	0		0	0	0	111.00
118.00		22,752	0	43,840,031	0	43,840,031	118.00
SUBTOTALS (SUM OF LINES 1-117)							

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 140213		Period: From 10/01/2013 To 09/30/2014		Worksheet B Part II Date/Time Prepared: 2/25/2015 8:07 am	
Cost Center Description			SOCIAL SERVICE	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	23.00	24.00	25.00	26.00	
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		111,647	0	111,647	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		0	0	0	192.00
200.00		Cross Foot Adjustments		150,800	150,800	0	150,800	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	22,752	150,800	44,102,478	0	44,102,478	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140213

Period:  
From 10/01/2013  
To 09/30/2014

Worksheet B-1  
Date/Time Prepared:  
2/25/2015 8:07 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	544,870				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		13,686,361			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	2,019	4,078	101,674,416		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	125,237	6,355,683	14,059,316	-63,047,460	5.00
7.00 00700	OPERATION OF PLANT	6,704	50,364	2,695,521	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	2,306	0	89,278	0	8.00
9.00 00900	HOUSEKEEPING	5,717	41,522	2,068,128	0	9.00
10.00 01000	DIETARY	22,721	12,552	478,971	0	10.00
11.00 01100	CAFETERIA	0	33,663	1,284,506	0	11.00
13.00 01300	NURSING ADMINISTRATION	2,876	49,118	1,734,410	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	18,334	195,853	572,129	0	14.00
15.00 01500	PHARMACY	7,568	0	2,720,974	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	1,071	7,202	1,988,833	0	16.00
17.00 01700	SOCIAL SERVICE	0	0	275,750	0	17.00
23.00 02300	PARAMED PRGM-(SPECIFY)	838	40,149	296,347	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	117,839	455,643	22,065,058	0	30.00
31.00 03100	INTENSIVE CARE UNIT	16,978	206,968	4,621,013	0	31.00
40.00 04000	SUBPROVIDER - I PF	11,079	18,949	1,586,214	0	40.00
41.00 04100	SUBPROVIDER - I RF	20,168	21,655	3,219,925	0	41.00
42.00 04200	SUBPROVIDER	0	0	0	0	42.00
43.00 04300	NURSERY	45,525	145,696	1,134,551	0	43.00
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
45.00 04500	NURSING FACILITY	0	0	0	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	54,900	1,784,350	8,252,830	0	50.00
51.00 05100	RECOVERY ROOM	4,337	30,871	1,153,302	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	266,311	2,769,836	0	52.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	24,514	1,731,560	6,378,538	0	54.00
54.01 05401	ULTRASOUND	3,002	163,274	1,027,941	0	54.01
57.00 05700	CT SCAN	2,693	384,937	919,530	0	57.00
58.00 05800	MRI	3,472	251,599	549,261	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00 06000	LABORATORY	599	41,373	3,449,226	0	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	60.01
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	4,988	131,512	0	63.00
65.00 06500	RESPIRATORY THERAPY	1,965	49,357	1,372,446	0	65.00
65.01 06501	SLEEP LAB	0	25,868	172,654	0	65.01
66.00 06600	PHYSICAL THERAPY	249	31,944	1,578,350	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	2,427	1,326,459	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00 06900	ELECTROCARDIOLOGY	1,456	71,629	1,022,801	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	1,040	8,112	219,414	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	527,339	0	0	73.00
74.00 07400	RENAL DIALYSIS	2,896	29,645	391,905	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00 09000	CLINIC	0	2,501	448,382	0	90.00
90.01 09001	HOMER GLEN LAB	0	2,255	498,978	0	90.01
90.02 09002	HOMER GLEN FEC	0	33,870	851,352	0	90.02
90.03 09003	WOMEN'S HEALTH	0	251,874	671,010	0	90.03
91.00 09100	EMERGENCY	31,891	347,936	5,475,636	0	91.00
91.01 09101	OP MENTAL HEALTH	3,067	1,629	387,218	0	91.01
91.02 09102	DIABETES CENTER	0	424	231,258	0	91.02
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
94.00 09400	HOME PROGRAM DIALYSIS	0	0	0	0	94.00
99.00 09900	CMHC	0	0	0	0	99.00
99.10 09910	CORF	0	0	0	0	99.10
101.00 10100	HOME HEALTH AGENCY	0	1,193	1,490,201	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
109.00 10900	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00 11000	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00 11100	ISLET ACQUISITION	0	0	0	0	111.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140213

Period:  
From 10/01/2013  
To 09/30/2014

Worksheet B-1

Date/Time Prepared:  
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Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)		
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)						
	1.00	2.00	4.00					
118.00	SUBTOTALS (SUM OF LINES 1-117)				5A	5.00	118.00	
	NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,809	0	13,452	0	115,568	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	29,363,768	14,738,710	34,975,510		63,047,460	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	53.891328	1.076890	0.343995		0.276123	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			113,199		13,609,210	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001113		0.059603	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140213

Period:  
From 10/01/2013  
To 09/30/2014

Worksheet B-1

Date/Time Prepared:  
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Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (NUMBER HOUSED)	
		7.00	8.00	9.00	10.00	11.00	
<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
7.00	00700	OPERATION OF PLANT	410,910				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,306	2,329,314			8.00
9.00	00900	HOUSEKEEPING	5,717	0	402,887		9.00
10.00	01000	DIETARY	22,721	26,737	22,721	278,514	10.00
11.00	01100	CAFETERIA	0	0	0	122,254	11.00
13.00	01300	NURSING ADMINISTRATION	2,876	0	2,876	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	18,334	5,873	18,334	0	14.00
15.00	01500	PHARMACY	7,568	0	7,568	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,071	0	1,071	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	420	17.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	838	85,233	838	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	117,839	883,117	117,839	186,225	34,631
31.00	03100	INTENSIVE CARE UNIT	16,978	115,786	16,978	47,690	5,852
40.00	04000	SUBPROVIDER - I/PF	11,079	0	11,079	15,426	2,458
41.00	04100	SUBPROVIDER - I/RF	20,168	123,686	20,168	29,173	4,689
42.00	04200	SUBPROVIDER	0	0	0	0	0
43.00	04300	NURSERY	45,525	0	45,525	0	1,546
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0
45.00	04500	NURSING FACILITY	0	0	0	0	0
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	54,900	352,716	54,900	0	12,133
51.00	05100	RECOVERY ROOM	4,337	23,216	4,337	0	1,205
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	149,852	0	0	3,833
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	24,514	98,408	24,514	0	9,815
54.01	05401	ULTRASOUND	3,002	7,193	3,002	0	1,299
57.00	05700	CT SCAN	2,693	7,193	2,693	0	1,238
58.00	05800	MRI	3,472	24,631	3,472	0	618
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	599	0	599	0	6,525
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	203
65.00	06500	RESPIRATORY THERAPY	1,965	0	1,965	0	2,263
65.01	06501	SLEEP LAB	0	0	0	0	334
66.00	06600	PHYSICAL THERAPY	249	25,775	249	0	2,080
67.00	06700	OCCUPATIONAL THERAPY	0	22,904	0	0	1,923
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	1,456	1,573	1,456	0	1,501
70.00	07000	ELECTROENCEPHALOGRAPHY	1,040	0	1,040	0	344
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
74.00	07400	RENAL DIALYSIS	2,896	0	2,896	0	391
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00	09000	CLINIC	0	956	0	0	960
90.01	09001	HOMER GLEN LAB	0	7,781	0	0	776
90.02	09002	HOMER GLEN FEC	0	42,518	0	0	1,129
90.03	09003	WOMEN'S HEALTH	0	81,619	0	0	984
91.00	09100	EMERGENCY	31,891	242,547	31,891	0	8,270
91.01	09101	OP MENTAL HEALTH	3,067	0	3,067	0	623
91.02	09102	DIABETES CENTER	0	0	0	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
<b>OTHER REIMBURSABLE COST CENTERS</b>							
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0
99.00	09900	CMHC	0	0	0	0	0
99.10	09910	CORF	0	0	0	0	0
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0
111.00	11100	ISLET ACQUISITION	0	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	409,101	2,329,314	401,078	278,514	122,183
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,809	0	1,809	0	71

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140213

Period:  
From 10/01/2013  
To 09/30/2014

Worksheet B-1

Date/Time Prepared:  
2/25/2015 8:07 am

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (NUMBER HOUSED)	
		7.00	8.00	9.00	10.00	11.00	
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	12,422,641	314,382	5,613,410	4,113,770	1,408,812
203.00		Unit cost multiplier (Wkst. B, Part I)	30.232024	0.134968	13.932964	14.770424	11.523647
204.00		Cost to be allocated (per Wkst. B, Part II)	998,739	141,405	623,118	1,475,606	103,481
205.00		Unit cost multiplier (Wkst. B, Part II)	2.430554	0.060707	1.546632	5.298139	0.846443

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140213

Period:  
From 10/01/2013  
To 09/30/2014

Worksheet B-1

Date/Time Prepared:  
2/25/2015 8:07 am

Cost Center Description		NURSING ADMINISTRATION  (DIRECT NRS ING)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE  (TIME SPENT)	
		13.00	14.00	15.00	16.00	17.00	
<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
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
13.00	01300	1,101,851					13.00
14.00	01400	0	23,094,771				14.00
15.00	01500	0	265,958	9,906,625			15.00
16.00	01600	0	19,131	0	38,911		16.00
17.00	01700	0	0	0	0	2,816	17.00
23.00	02300	0	149,466	33,402	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	720,321	1,472,829	2,949	15,399	2,446	30.00
31.00	03100	121,722	484,948	2,249	4,740	150	31.00
40.00	04000	0	26,387	0	1,237	0	40.00
41.00	04100	97,531	89,406	1,275	1,203	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	32,151	194,457	0	1,663	0	43.00
44.00	04400	0	0	0	0	0	44.00
45.00	04500	0	0	0	0	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	0	2,304,970	0	0	0	50.00
51.00	05100	0	34,412	0	0	0	51.00
52.00	05200	79,727	266,158	0	0	0	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	0	709,980	22,442	0	0	54.00
54.01	05401	0	83,742	0	0	0	54.01
57.00	05700	0	231,321	0	0	0	57.00
58.00	05800	0	47,229	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	0	2,752,501	0	0	0	60.00
60.01	06001	0	0	0	0	0	60.01
63.00	06300	0	167,152	0	0	0	63.00
65.00	06500	0	172,788	0	0	0	65.00
65.01	06501	0	12,015	0	0	0	65.01
66.00	06600	0	18,044	0	3,582	0	66.00
67.00	06700	0	25,375	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	0	30,625	0	0	0	69.00
70.00	07000	0	3,778	0	832	0	70.00
71.00	07100	0	12,476,086	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	9,842,168	0	0	73.00
74.00	07400	8,133	85,314	0	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	0	35,468	0	157	35	90.00
90.01	09001	0	141,445	0	0	0	90.01
90.02	09002	0	69,525	0	0	0	90.02
90.03	09003	0	65,315	0	0	0	90.03
91.00	09100	0	603,208	2,140	10,098	185	91.00
91.01	09101	0	7,061	0	0	0	91.01
91.02	09102	0	3,847	0	0	0	91.02
92.00	09200	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
94.00	09400	0	0	0	0	0	94.00
99.00	09900	0	0	0	0	0	99.00
99.10	09910	0	0	0	0	0	99.10
101.00	10100	42,266	44,830	0	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	10900	0	0	0	0	0	109.00
110.00	11000	0	0	0	0	0	110.00
111.00	11100	0	0	0	0	0	111.00
118.00		1,101,851	23,094,771	9,906,625	38,911	2,816	118.00



COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140213

Period:  
From 10/01/2013  
To 09/30/2014

Worksheet B-1

Date/Time Prepared:  
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Cost Center Description		NURSING ADMINISTRATION  (DIRECT NRS ING)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	
		13.00	14.00	15.00	16.00	17.00	
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,443,529	3,360,580	7,826,261	4,655,010	477,780
203.00		Unit cost multiplier (Wkst. B, Part I)	3.125222	0.145513	0.790003	119.632238	169.666193
204.00		Cost to be allocated (per Wkst. B, Part II)	376,959	1,392,518	806,062	289,464	22,752
205.00		Unit cost multiplier (Wkst. B, Part II)	0.342114	0.060296	0.081366	7.439130	8.079545

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140213

Period:  
From 10/01/2013  
To 09/30/2014

Worksheet B-1  
Date/Time Prepared:  
2/25/2015 8:07 am

Cost Center Description		PARAMED PRGM (ASSIGNED TIME)	
		23.00	
<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
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
23.00	02300	PARAMED PRGM- (SPECIFY)	23.00
		7,841	
<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
42.00	04200	SUBPROVIDER	42.00
43.00	04300	NURSERY	43.00
44.00	04400	SKILLED NURSING FACILITY	44.00
45.00	04500	NURSING FACILITY	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>			
50.00	05000	OPERATING ROOM	50.00
51.00	05100	RECOVERY ROOM	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
54.01	05401	ULTRASOUND	54.01
57.00	05700	CT SCAN	57.00
58.00	05800	MRI	58.00
59.00	05900	CARDIAC CATHETERIZATION	59.00
60.00	06000	LABORATORY	60.00
60.01	06001	BLOOD LABORATORY	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	63.00
65.00	06500	RESPIRATORY THERAPY	65.00
65.01	06501	SLEEP LAB	65.01
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
74.00	07400	RENAL DIALYSIS	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>			
88.00	08800	RURAL HEALTH CLINIC	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	89.00
90.00	09000	CLINIC	90.00
90.01	09001	HOMER GLEN LAB	90.01
90.02	09002	HOMER GLEN FEC	90.02
90.03	09003	WOMEN'S HEALTH	90.03
91.00	09100	EMERGENCY	91.00
91.01	09101	OP MENTAL HEALTH	91.01
91.02	09102	DIABETES CENTER	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>			
94.00	09400	HOME PROGRAM DIALYSIS	94.00
99.00	09900	CMHC	99.00
99.10	09910	CORF	99.10
101.00	10100	HOME HEALTH AGENCY	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>			
109.00	10900	PANCREAS ACQUISITION	109.00
110.00	11000	INTESTINAL ACQUISITION	110.00
111.00	11100	ISLET ACQUISITION	111.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	118.00
		7,841	
<b>NONREIMBURSABLE COST CENTERS</b>			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140213

Period:  
From 10/01/2013  
To 09/30/2014

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Cost Center Description		PARAMED ED PRGM (ASSIGNED TIME)	
		23.00	
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	192.00
200.00	Cross Foot Adjustments		200.00
201.00	Negative Cost Centers		201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	975,387	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	124.395740	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	150,800	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	19.232241	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140213

Period:  
From 10/01/2013  
To 09/30/2014

Worksheet C  
Part I  
Date/Time Prepared:  
2/25/2015 8:07 am

		Title XVIIII		Hospital		PPS		
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs		
				Total Costs	RCE Disallowance			
		1.00	2.00	3.00	4.00	5.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	62,577,846		62,577,846	0	62,577,846	30.00
31.00	03100	INTENSIVE CARE UNIT	13,384,140		13,384,140	8,454	13,392,594	31.00
40.00	04000	SUBPROVIDER - I/PF	4,886,590		4,886,590	0	4,886,590	40.00
41.00	04100	SUBPROVIDER - I/PF	9,550,585		9,550,585	0	9,550,585	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	42.00
43.00	04300	NURSERY	9,044,041		9,044,041	0	9,044,041	43.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
45.00	04500	NURSING FACILITY	0		0	0	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	32,648,642		32,648,642	2,500	32,651,142	50.00
51.00	05100	RECOVERY ROOM	2,592,724		2,592,724	0	2,592,724	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,060,373		6,060,373	0	6,060,373	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	26,350,547		26,350,547	0	26,350,547	54.00
54.01	05401	ULTRASOUND	2,569,308		2,569,308	0	2,569,308	54.01
57.00	05700	CT SCAN	3,380,525		3,380,525	0	3,380,525	57.00
58.00	05800	MRI	2,277,390		2,277,390	0	2,277,390	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	12,272,185		12,272,185	0	12,272,185	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,323,338		2,323,338	0	2,323,338	63.00
65.00	06500	RESPIRATORY THERAPY	3,086,309	0	3,086,309	612	3,086,921	65.00
65.01	06501	SLEEP LAB	510,558	0	510,558	0	510,558	65.01
66.00	06600	PHYSICAL THERAPY	3,859,333	0	3,859,333	0	3,859,333	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,578,675	0	2,578,675	0	2,578,675	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,164,685		2,164,685	0	2,164,685	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	621,255		621,255	0	621,255	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	17,533,267		17,533,267	0	17,533,267	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	19,928,604		19,928,604	0	19,928,604	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	21,059,848		21,059,848	0	21,059,848	73.00
74.00	07400	RENAL DIALYSIS	1,243,992		1,243,992	8,426	1,252,418	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000	CLINIC	1,239,368		1,239,368	0	1,239,368	90.00
90.01	09001	HOMER GLEN LAB	1,165,112		1,165,112	0	1,165,112	90.01
90.02	09002	HOMER GLEN FEC	1,947,140		1,947,140	0	1,947,140	90.02
90.03	09003	WOMEN'S HEALTH	2,154,097		2,154,097	0	2,154,097	90.03
91.00	09100	EMERGENCY	16,801,297		16,801,297	24,022	16,825,319	91.00
91.01	09101	OP MENTAL HEALTH	1,022,460		1,022,460	0	1,022,460	91.01
91.02	09102	DIABETES CENTER	406,740		406,740	59	406,799	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	6,585,513		6,585,513	0	6,585,513	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
94.00	09400	HOME PROGRAM DIALYSIS	0		0	0	0	94.00
99.00	09900	CMHC	0		0	0	0	99.00
99.10	09910	CORF	0		0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	3,909,726		3,909,726	0	3,909,726	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
109.00	10900	PANCREAS ACQUISITION	0		0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0		0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0		0	0	0	111.00
200.00		Subtotal (see instructions)	297,736,213	0	297,736,213	44,073	297,780,286	200.00
201.00		Less Observation Beds	6,585,513		6,585,513	0	6,585,513	201.00
202.00		Total (see instructions)	291,150,700	0	291,150,700	44,073	291,194,773	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140213

Period:  
From 10/01/2013  
To 09/30/2014

Worksheet C  
Part I  
Date/Time Prepared:  
2/25/2015 8:07 am

		Title XVIIII			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
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	60,306,633		60,306,633		30.00
31.00	03100	INTENSIVE CARE UNIT	15,443,790		15,443,790		31.00
40.00	04000	SUBPROVIDER - IPF	4,995,564		4,995,564		40.00
41.00	04100	SUBPROVIDER - IRF	9,447,432		9,447,432		41.00
42.00	04200	SUBPROVIDER	0		0		42.00
43.00	04300	NURSERY	8,686,916		8,686,916		43.00
44.00	04400	SKILLED NURSING FACILITY	0		0		44.00
45.00	04500	NURSING FACILITY	0		0		45.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	71,177,981	88,130,176	159,308,157	0.204940	50.00
51.00	05100	RECOVERY ROOM	13,144,648	10,008,441	23,153,089	0.111982	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,794,980	780,780	8,575,760	0.706686	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	40,069,967	104,271,502	144,341,469	0.182557	54.00
54.01	05401	ULTRASOUND	7,154,155	17,092,068	24,246,223	0.105967	54.01
57.00	05700	CT SCAN	29,236,195	58,717,548	87,953,743	0.038435	57.00
58.00	05800	MRI	8,803,606	19,634,502	28,438,108	0.080082	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	63,790,994	87,614,083	151,405,077	0.081055	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	7,427,207	860,389	8,287,596	0.280339	63.00
65.00	06500	RESPIRATORY THERAPY	18,740,382	2,364,403	21,104,785	0.146237	65.00
65.01	06501	SLEEP LAB	0	2,873,576	2,873,576	0.177673	65.01
66.00	06600	PHYSICAL THERAPY	7,442,974	3,771,545	11,214,519	0.344137	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,011,670	7,429,854	12,441,524	0.207264	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	10,255,972	7,539,077	17,795,049	0.121645	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	683,115	1,773,568	2,456,683	0.252884	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	22,105,321	10,986,056	33,091,377	0.529844	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	25,321,804	9,420,796	34,742,600	0.573607	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	46,392,857	18,487,479	64,880,336	0.324595	73.00
74.00	07400	RENAL DIALYSIS	3,522,200	0	3,522,200	0.353186	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	09000	CLINIC	27,035	827,457	854,492	1.450415	90.00
90.01	09001	HOMER GLEN LAB	396,468	4,611,239	5,007,707	0.232664	90.01
90.02	09002	HOMER GLEN FEC	481,855	8,383,743	8,865,598	0.219629	90.02
90.03	09003	WOMEN'S HEALTH	24,348	5,523,228	5,547,576	0.388295	90.03
91.00	09100	EMERGENCY	24,351,319	53,616,712	77,968,031	0.215490	91.00
91.01	09101	OP MENTAL HEALTH	0	1,828,506	1,828,506	0.559178	91.01
91.02	09102	DIABETES CENTER	70,842	345,058	415,900	0.977975	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,151,152	6,164,859	7,316,011	0.900151	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0.000000	94.00
99.00	09900	CMHC	0	0	0		99.00
99.10	09910	CORF	0	0	0		99.10
101.00	10100	HOME HEALTH AGENCY	0	4,882,767	4,882,767		101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	10900	PANCREAS ACQUISITION	0	0	0		109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0		110.00
111.00	11100	ISLET ACQUISITION	0	0	0		111.00
200.00		Subtotal (see instructions)	513,459,382	537,939,412	1,051,398,794		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	513,459,382	537,939,412	1,051,398,794		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 140213	Period: From 10/01/2013 To 09/30/2014	Worksheet C Part I Date/Time Prepared: 2/25/2015 8:07 am
			Title XVIII	Hospital	PPS
Cost Center Description			PPS Inpatient Ratio		
			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
42.00	04200	SUBPROVIDER			42.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
45.00	04500	NURSING FACILITY			45.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.204956		50.00
51.00	05100	RECOVERY ROOM	0.111982		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.706686		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.182557		54.00
54.01	05401	ULTRASOUND	0.105967		54.01
57.00	05700	CT SCAN	0.038435		57.00
58.00	05800	MRI	0.080082		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.081055		60.00
60.01	06001	BLOOD LABORATORY	0.000000		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.280339		63.00
65.00	06500	RESPIRATORY THERAPY	0.146266		65.00
65.01	06501	SLEEP LAB	0.177673		65.01
66.00	06600	PHYSICAL THERAPY	0.344137		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.207264		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.121645		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.252884		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.529844		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.573607		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.324595		73.00
74.00	07400	RENAL DIALYSIS	0.355578		74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC			88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER			89.00
90.00	09000	CLINIC	1.450415		90.00
90.01	09001	HOMER GLEN LAB	0.232664		90.01
90.02	09002	HOMER GLEN FEC	0.219629		90.02
90.03	09003	WOMEN'S HEALTH	0.388295		90.03
91.00	09100	EMERGENCY	0.215798		91.00
91.01	09101	OP MENTAL HEALTH	0.559178		91.01
91.02	09102	DIABETES CENTER	0.978117		91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.900151		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
94.00	09400	HOME PROGRAM DIALYSIS	0.000000		94.00
99.00	09900	CMHC			99.00
99.10	09910	CORF			99.10
101.00	10100	HOME HEALTH AGENCY			101.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
109.00	10900	PANCREAS ACQUISITION			109.00
110.00	11000	INTESTINAL ACQUISITION			110.00
111.00	11100	ISLET ACQUISITION			111.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140213

Period:  
From 10/01/2013  
To 09/30/2014

Worksheet C  
Part I  
Date/Time Prepared:  
2/25/2015 8:07 am

		Title XIX		Hospital		PPS	
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	
				Total Costs	RCE Disallowance		
		1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS		62,577,846	0	62,577,846	30.00
31.00	03100	INTENSIVE CARE UNIT		13,384,140	8,454	13,392,594	31.00
40.00	04000	SUBPROVIDER - I/PF		4,886,590	0	4,886,590	40.00
41.00	04100	SUBPROVIDER - I/RF		9,550,585	0	9,550,585	41.00
42.00	04200	SUBPROVIDER		0	0	0	42.00
43.00	04300	NURSERY		9,044,041	0	9,044,041	43.00
44.00	04400	SKILLED NURSING FACILITY		0	0	0	44.00
45.00	04500	NURSING FACILITY		0	0	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM		32,648,642	2,500	32,651,142	50.00
51.00	05100	RECOVERY ROOM		2,592,724	0	2,592,724	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		6,060,373	0	6,060,373	52.00
53.00	05300	ANESTHESIOLOGY		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		26,350,547	0	26,350,547	54.00
54.01	05401	ULTRASOUND		2,569,308	0	2,569,308	54.01
57.00	05700	CT SCAN		3,380,525	0	3,380,525	57.00
58.00	05800	MRI		2,277,390	0	2,277,390	58.00
59.00	05900	CARDIAC CATHETERIZATION		0	0	0	59.00
60.00	06000	LABORATORY		12,272,185	0	12,272,185	60.00
60.01	06001	BLOOD LABORATORY		0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.		2,323,338	0	2,323,338	63.00
65.00	06500	RESPIRATORY THERAPY	0	3,086,309	612	3,086,921	65.00
65.01	06501	SLEEP LAB	0	510,558	0	510,558	65.01
66.00	06600	PHYSICAL THERAPY	0	3,859,333	0	3,859,333	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,578,675	0	2,578,675	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY		2,164,685	0	2,164,685	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY		621,255	0	621,255	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		17,533,267	0	17,533,267	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		19,928,604	0	19,928,604	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		21,059,848	0	21,059,848	73.00
74.00	07400	RENAL DIALYSIS		1,243,992	8,426	1,252,418	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC		0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	89.00
90.00	09000	CLINIC		1,239,368	0	1,239,368	90.00
90.01	09001	HOMER GLEN LAB		1,165,112	0	1,165,112	90.01
90.02	09002	HOMER GLEN FEC		1,947,140	0	1,947,140	90.02
90.03	09003	WOMEN'S HEALTH		2,154,097	0	2,154,097	90.03
91.00	09100	EMERGENCY		16,801,297	24,022	16,825,319	91.00
91.01	09101	OP MENTAL HEALTH		1,022,460	0	1,022,460	91.01
91.02	09102	DIABETES CENTER		406,740	59	406,799	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		6,585,513	0	6,585,513	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
94.00	09400	HOME PROGRAM DIALYSIS		0	0	0	94.00
99.00	09900	CMHC		0	0	0	99.00
99.10	09910	CORF		0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY		3,909,726	0	3,909,726	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	10900	PANCREAS ACQUISITION		0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION		0	0	0	110.00
111.00	11100	ISLET ACQUISITION		0	0	0	111.00
200.00		Subtotal (see instructions)	0	297,736,213	44,073	297,780,286	200.00
201.00		Less Observation Beds		6,585,513	0	6,585,513	201.00
202.00		Total (see instructions)	0	291,150,700	44,073	291,194,773	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140213

Period:  
From 10/01/2013  
To 09/30/2014

Worksheet C  
Part I  
Date/Time Prepared:  
2/25/2015 8:07 am

		Title XIX			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
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	60,306,633		60,306,633		30.00
31.00	03100	INTENSIVE CARE UNIT	15,443,790		15,443,790		31.00
40.00	04000	SUBPROVIDER - IPF	4,995,564		4,995,564		40.00
41.00	04100	SUBPROVIDER - IRF	9,447,432		9,447,432		41.00
42.00	04200	SUBPROVIDER	0		0		42.00
43.00	04300	NURSERY	8,686,916		8,686,916		43.00
44.00	04400	SKILLED NURSING FACILITY	0		0		44.00
45.00	04500	NURSING FACILITY	0		0		45.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	71,177,981	88,130,176	159,308,157	0.204940	50.00
51.00	05100	RECOVERY ROOM	13,144,648	10,008,441	23,153,089	0.111982	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,794,980	780,780	8,575,760	0.706686	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	40,069,967	104,271,502	144,341,469	0.182557	54.00
54.01	05401	ULTRASOUND	7,154,155	17,092,068	24,246,223	0.105967	54.01
57.00	05700	CT SCAN	29,236,195	58,717,548	87,953,743	0.038435	57.00
58.00	05800	MRI	8,803,606	19,634,502	28,438,108	0.080082	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	63,790,994	87,614,083	151,405,077	0.081055	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	7,427,207	860,389	8,287,596	0.280339	63.00
65.00	06500	RESPIRATORY THERAPY	18,740,382	2,364,403	21,104,785	0.146237	65.00
65.01	06501	SLEEP LAB	0	2,873,576	2,873,576	0.177673	65.01
66.00	06600	PHYSICAL THERAPY	7,442,974	3,771,545	11,214,519	0.344137	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,011,670	7,429,854	12,441,524	0.207264	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	10,255,972	7,539,077	17,795,049	0.121645	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	683,115	1,773,568	2,456,683	0.252884	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	22,105,321	10,986,056	33,091,377	0.529844	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	25,321,804	9,420,796	34,742,600	0.573607	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	46,392,857	18,487,479	64,880,336	0.324595	73.00
74.00	07400	RENAL DIALYSIS	3,522,200	0	3,522,200	0.353186	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	89.00
90.00	09000	CLINIC	27,035	827,457	854,492	1.450415	90.00
90.01	09001	HOMER GLEN LAB	396,468	4,611,239	5,007,707	0.232664	90.01
90.02	09002	HOMER GLEN FEC	481,855	8,383,743	8,865,598	0.219629	90.02
90.03	09003	WOMEN'S HEALTH	24,348	5,523,228	5,547,576	0.388295	90.03
91.00	09100	EMERGENCY	24,351,319	53,616,712	77,968,031	0.215490	91.00
91.01	09101	OP MENTAL HEALTH	0	1,828,506	1,828,506	0.559178	91.01
91.02	09102	DIABETES CENTER	70,842	345,058	415,900	0.977975	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,151,152	6,164,859	7,316,011	0.900151	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0.000000	94.00
99.00	09900	CMHC	0	0	0		99.00
99.10	09910	CORF	0	0	0		99.10
101.00	10100	HOME HEALTH AGENCY	0	4,882,767	4,882,767		101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	10900	PANCREAS ACQUISITION	0	0	0		109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0		110.00
111.00	11100	ISLET ACQUISITION	0	0	0		111.00
200.00		Subtotal (see instructions)	513,459,382	537,939,412	1,051,398,794		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	513,459,382	537,939,412	1,051,398,794		202.00



COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 140213	Period: From 10/01/2013 To 09/30/2014	Worksheet C Part I Date/Time Prepared: 2/25/2015 8:07 am
Cost Center Description			PPS Inpatient Ratio	Title XIX	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
42.00	04200	SUBPROVIDER			42.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
45.00	04500	NURSING FACILITY			45.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.204956		50.00
51.00	05100	RECOVERY ROOM	0.111982		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.706686		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.182557		54.00
54.01	05401	ULTRASOUND	0.105967		54.01
57.00	05700	CT SCAN	0.038435		57.00
58.00	05800	MRI	0.080082		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.081055		60.00
60.01	06001	BLOOD LABORATORY	0.000000		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.280339		63.00
65.00	06500	RESPIRATORY THERAPY	0.146266		65.00
65.01	06501	SLEEP LAB	0.177673		65.01
66.00	06600	PHYSICAL THERAPY	0.344137		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.207264		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.121645		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.252884		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.529844		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.573607		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.324595		73.00
74.00	07400	RENAL DIALYSIS	0.355578		74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
90.00	09000	CLINIC	1.450415		90.00
90.01	09001	HOMER GLEN LAB	0.232664		90.01
90.02	09002	HOMER GLEN FEC	0.219629		90.02
90.03	09003	WOMEN'S HEALTH	0.388295		90.03
91.00	09100	EMERGENCY	0.215798		91.00
91.01	09101	OP MENTAL HEALTH	0.559178		91.01
91.02	09102	DIABETES CENTER	0.978117		91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.900151		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
94.00	09400	HOME PROGRAM DIALYSIS	0.000000		94.00
99.00	09900	CMHC			99.00
99.10	09910	CORF			99.10
101.00	10100	HOME HEALTH AGENCY			101.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
109.00	10900	PANCREAS ACQUISITION			109.00
110.00	11000	INTESTINAL ACQUISITION			110.00
111.00	11100	ISLET ACQUISITION			111.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

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

Provider CCN: 140213

Period:  
From 10/01/2013  
To 09/30/2014

Worksheet C  
Part II  
Date/Time Prepared:  
2/25/2015 8:07 am

Cost Center Description		Title XIX			Hospital		PPS
		Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	32,648,642	6,663,535	25,985,107	0	0	50.00
51.00	05100 RECOVERY ROOM	2,592,724	401,131	2,191,593	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	6,060,373	610,420	5,449,953	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	26,350,547	4,517,918	21,832,629	0	0	54.00
54.01	05401 ULTRASOUND	2,569,308	469,777	2,099,531	0	0	54.01
57.00	05700 CT SCAN	3,380,525	736,883	2,643,642	0	0	57.00
58.00	05800 MRI	2,277,390	575,739	1,701,651	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	12,272,185	804,278	11,467,907	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	2,323,338	123,038	2,200,300	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	3,086,309	316,803	2,769,506	0	0	65.00
65.01	06501 SLEEP LAB	510,558	52,641	457,917	0	0	65.01
66.00	06600 PHYSICAL THERAPY	3,859,333	239,949	3,619,384	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	2,578,675	127,727	2,450,948	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	2,164,685	261,333	1,903,352	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	621,255	97,883	523,372	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	17,533,267	1,486,375	16,046,892	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	19,928,604	930,792	18,997,812	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	21,059,848	1,989,173	19,070,675	0	0	73.00
74.00	07400 RENAL DIALYSIS	1,243,992	258,355	985,637	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000 CLINIC	1,239,368	63,621	1,175,747	0	0	90.00
90.01	09001 HOMER GLEN LAB	1,165,112	65,631	1,099,481	0	0	90.01
90.02	09002 HOMER GLEN FEC	1,947,140	134,747	1,812,393	0	0	90.02
90.03	09003 WOMEN'S HEALTH	2,154,097	380,836	1,773,261	0	0	90.03
91.00	09100 EMERGENCY	16,801,297	2,977,674	13,823,623	0	0	91.00
91.01	09101 OP MENTAL HEALTH	1,022,460	221,667	800,793	0	0	91.01
91.02	09102 DIABETES CENTER	406,740	19,917	386,823	0	0	91.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	6,585,513	1,176,561	5,408,952	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
99.00	09900 CMHC	0	0	0	0	0	99.00
99.10	09910 CORF	0	0	0	0	0	99.10
101.00	10100 HOME HEALTH AGENCY	3,909,726	196,242	3,713,484	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	10900 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100 ISLET ACQUISITION	0	0	0	0	0	111.00
200.00	Subtotal (sum of lines 50 thru 199)	198,293,011	25,900,646	172,392,365	0	0	200.00
201.00	Less Observation Beds	6,585,513	1,176,561	5,408,952	0	0	201.00
202.00	Total (Line 200 minus Line 201)	191,707,498	24,724,085	166,983,413	0	0	202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY		Provider CCN: 140213	Period: From 10/01/2013 To 09/30/2014	Worksheet C Part II Date/Time Prepared: 2/25/2015 8:07 am
		Title XIX	Hospital	PPS

Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
	6.00	7.00	8.00		
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	32,648,642	159,308,157	0.204940	50.00
51.00	05100 RECOVERY ROOM	2,592,724	23,153,089	0.111982	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	6,060,373	8,575,760	0.706686	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0.000000	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	26,350,547	144,341,469	0.182557	54.00
54.01	05401 ULTRASOUND	2,569,308	24,246,223	0.105967	54.01
57.00	05700 CT SCAN	3,380,525	87,953,743	0.038435	57.00
58.00	05800 MRI	2,277,390	28,438,108	0.080082	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000	59.00
60.00	06000 LABORATORY	12,272,185	151,405,077	0.081055	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	2,323,338	8,287,596	0.280339	63.00
65.00	06500 RESPIRATORY THERAPY	3,086,309	21,104,785	0.146237	65.00
65.01	06501 SLEEP LAB	510,558	2,873,576	0.177673	65.01
66.00	06600 PHYSICAL THERAPY	3,859,333	11,214,519	0.344137	66.00
67.00	06700 OCCUPATIONAL THERAPY	2,578,675	12,441,524	0.207264	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0.000000	68.00
69.00	06900 ELECTROCARDIOLOGY	2,164,685	17,795,049	0.121645	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	621,255	2,456,683	0.252884	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	17,533,267	33,091,377	0.529844	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	19,928,604	34,742,600	0.573607	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	21,059,848	64,880,336	0.324595	73.00
74.00	07400 RENAL DIALYSIS	1,243,992	3,522,200	0.353186	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800 RURAL HEALTH CLINIC	0	0	0.000000	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	89.00
90.00	09000 CLINIC	1,239,368	854,492	1.450415	90.00
90.01	09001 HOMER GLEN LAB	1,165,112	5,007,707	0.232664	90.01
90.02	09002 HOMER GLEN FEC	1,947,140	8,865,598	0.219629	90.02
90.03	09003 WOMEN'S HEALTH	2,154,097	5,547,576	0.388295	90.03
91.00	09100 EMERGENCY	16,801,297	77,968,031	0.215490	91.00
91.01	09101 OP MENTAL HEALTH	1,022,460	1,828,506	0.559178	91.01
91.02	09102 DIABETES CENTER	406,740	415,900	0.977975	91.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	6,585,513	7,316,011	0.900151	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0.000000	94.00
99.00	09900 CMHC	0	0	0.000000	99.00
99.10	09910 CORF	0	0	0.000000	99.10
101.00	10100 HOME HEALTH AGENCY	3,909,726	4,882,767	0.800719	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
109.00	10900 PANCREAS ACQUISITION	0	0	0.000000	109.00
110.00	11000 INTESTINAL ACQUISITION	0	0	0.000000	110.00
111.00	11100 ISLET ACQUISITION	0	0	0.000000	111.00
200.00	Subtotal (sum of lines 50 thru 199)	198,293,011	952,518,459		200.00
201.00	Less Observation Beds	6,585,513	0		201.00
202.00	Total (Line 200 minus Line 201)	191,707,498	952,518,459		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 140213	Period: From 10/01/2013 To 09/30/2014	Worksheet D Part I Date/Time Prepared: 2/25/2015 8:07 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)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	4.00	5.00	
30.00	ADULTS & PEDIATRICS	11,180,118	0	11,180,118	61,775	180.98	30.00
31.00	INTENSIVE CARE UNIT	2,083,908		2,083,908	5,843	356.65	31.00
40.00	SUBPROVIDER - IPF	943,248	0	943,248	4,575	206.17	40.00
41.00	SUBPROVIDER - IRF	1,767,275	0	1,767,275	7,472	236.52	41.00
42.00	SUBPROVIDER	0	0	0	0	0.00	42.00
43.00	NURSERY	3,141,397		3,141,397	6,375	492.77	43.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
45.00	NURSING FACILITY	0		0	0	0.00	45.00
200.00	Total (lines 30-199)	19,115,946		19,115,946	86,040		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
INPATIENT ROUTINE SERVICE COST CENTERS		6.00	7.00				
30.00	ADULTS & PEDIATRICS	26,966	4,880,307				
31.00	INTENSIVE CARE UNIT	2,925	1,043,201				
40.00	SUBPROVIDER - IPF	1,259	259,568				
41.00	SUBPROVIDER - IRF	4,908	1,160,840				
42.00	SUBPROVIDER	0	0				
43.00	NURSERY	0	0				
44.00	SKILLED NURSING FACILITY	0	0				
45.00	NURSING FACILITY	0	0				
200.00	Total (lines 30-199)	36,058	7,343,916				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 140213	Period: From 10/01/2013 To 09/30/2014	Worksheet D Part II Date/Time Prepared: 2/25/2015 8:07 am
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	6,663,535	159,308,157	0.041828	20,149,875	842,829	50.00
51.00	05100 RECOVERY ROOM	401,131	23,153,089	0.017325	3,479,328	60,279	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	610,420	8,575,760	0.071180	3,163	225	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	4,517,918	144,341,469	0.031300	19,047,143	596,176	54.00
54.01	05401 ULTRASOUND	469,777	24,246,223	0.019375	3,527,847	68,352	54.01
57.00	05700 CT SCAN	736,883	87,953,743	0.008378	14,637,219	122,631	57.00
58.00	05800 MRI	575,739	28,438,108	0.020245	4,321,217	87,483	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000 LABORATORY	804,278	151,405,077	0.005312	25,750,729	136,788	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	123,038	8,287,596	0.014846	7,153,617	106,203	63.00
65.00	06500 RESPIRATORY THERAPY	316,803	21,104,785	0.015011	10,630,311	159,572	65.00
65.01	06501 SLEEP LAB	52,641	2,873,576	0.018319	0	0	65.01
66.00	06600 PHYSICAL THERAPY	239,949	11,214,519	0.021396	3,103,019	66,392	66.00
67.00	06700 OCCUPATIONAL THERAPY	127,727	12,441,524	0.010266	1,572,774	16,146	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	261,333	17,795,049	0.014686	6,218,092	91,319	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	97,883	2,456,683	0.039844	372,423	14,839	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1,486,375	33,091,377	0.044917	14,744,809	662,293	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	930,792	34,742,600	0.026791	9,835,062	263,491	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,989,173	64,880,336	0.030659	19,919,825	610,722	73.00
74.00	07400 RENAL DIALYSIS	258,355	3,522,200	0.073350	2,199,374	161,324	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000 CLINIC	63,621	854,492	0.074455	24,668	1,837	90.00
90.01	09001 HOMER GLEN LAB	65,631	5,007,707	0.013106	381,279	4,997	90.01
90.02	09002 HOMER GLEN FEC	134,747	8,865,598	0.015199	125,133	1,902	90.02
90.03	09003 WOMEN'S HEALTH	380,836	5,547,576	0.068649	1,829	126	90.03
91.00	09100 EMERGENCY	2,977,674	77,968,031	0.038191	12,359,294	472,014	91.00
91.01	09101 OP MENTAL HEALTH	221,667	1,828,506	0.121228	0	0	91.01
91.02	09102 DIABETES CENTER	19,917	415,900	0.047889	0	0	91.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1,176,561	7,316,011	0.160820	600,151	96,516	92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0.000000	0	0	94.00
200.00	Total (lines 50-199)	25,704,404	947,635,692		180,158,181	4,644,456	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 140213	Period: From 10/01/2013 To 09/30/2014	Worksheet D Part III Date/Time Prepared: 2/25/2015 8:07 am
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Cost Center Description			Title XVIII		Hospital		PPS
Cost Center Description			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	70,657	0	0	70,657 31.00
40.00	04000	SUBPROVIDER - IPF	0	20,898	0	0	20,898 40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0 41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0 42.00
43.00	04300	NURSERY	0	0	0	0	0 43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0 44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0 45.00
200.00		Total (lines 30-199)	0	91,555	0	0	91,555 200.00
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	61,775	0.00	26,966	0	30.00
31.00	03100	INTENSIVE CARE UNIT	5,843	12.09	2,925	35,363	31.00
40.00	04000	SUBPROVIDER - IPF	4,575	4.57	1,259	5,754	40.00
41.00	04100	SUBPROVIDER - IRF	7,472	0.00	4,908	0	41.00
42.00	04200	SUBPROVIDER	0	0.00	0	0	42.00
43.00	04300	NURSERY	6,375	0.00	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0.00	0	0	44.00
45.00	04500	NURSING FACILITY	0	0.00	0	0	45.00
200.00		Total (lines 30-199)	86,040		36,058	41,117	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140213	Period: From 10/01/2013 To 09/30/2014	Worksheet D Part IV Date/Time Prepared: 2/25/2015 8:07 am
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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	44,409	0	44,409	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	36,821	0	36,821	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	34,831	0	34,831	65.00
65.01	06501	SLEEP LAB	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	31,845	0	31,845	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	735,926	0	735,926	91.00
91.01	09101	OP MENTAL HEALTH	0	0	0	0	0	91.01
91.02	09102	DIABETES CENTER	0	0	0	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
200.00		Total (lines 50-199)	0	0	883,832	0	883,832	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140213	Period: From 10/01/2013 To 09/30/2014	Worksheet D Part IV Date/Time Prepared: 2/25/2015 8:07 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 Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	PPS
		6.00	7.00	8.00	9.00	10.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	44,409	159,308,157	0.000279	0.000279	20,149,875	50.00
51.00	05100 RECOVERY ROOM	0	23,153,089	0.000000	0.000000	3,479,328	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	36,821	8,575,760	0.004294	0.004294	3,163	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	144,341,469	0.000000	0.000000	19,047,143	54.00
54.01	05401 ULTRASOUND	0	24,246,223	0.000000	0.000000	3,527,847	54.01
57.00	05700 CT SCAN	0	87,953,743	0.000000	0.000000	14,637,219	57.00
58.00	05800 MRI	0	28,438,108	0.000000	0.000000	4,321,217	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000 LABORATORY	0	151,405,077	0.000000	0.000000	25,750,729	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	8,287,596	0.000000	0.000000	7,153,617	63.00
65.00	06500 RESPIRATORY THERAPY	34,831	21,104,785	0.001650	0.001650	10,630,311	65.00
65.01	06501 SLEEP LAB	0	2,873,576	0.000000	0.000000	0	65.01
66.00	06600 PHYSICAL THERAPY	0	11,214,519	0.000000	0.000000	3,103,019	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	12,441,524	0.000000	0.000000	1,572,774	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	06900 ELECTROCARDIOLOGY	31,845	17,795,049	0.001790	0.001790	6,218,092	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	2,456,683	0.000000	0.000000	372,423	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	33,091,377	0.000000	0.000000	14,744,809	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	34,742,600	0.000000	0.000000	9,835,062	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	64,880,336	0.000000	0.000000	19,919,825	73.00
74.00	07400 RENAL DIALYSIS	0	3,522,200	0.000000	0.000000	2,199,374	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	09000 CLINIC	0	854,492	0.000000	0.000000	24,668	90.00
90.01	09001 HOMER GLEN LAB	0	5,007,707	0.000000	0.000000	381,279	90.01
90.02	09002 HOMER GLEN FEC	0	8,865,598	0.000000	0.000000	125,133	90.02
90.03	09003 WOMEN'S HEALTH	0	5,547,576	0.000000	0.000000	1,829	90.03
91.00	09100 EMERGENCY	735,926	77,968,031	0.009439	0.009439	12,359,294	91.00
91.01	09101 OP MENTAL HEALTH	0	1,828,506	0.000000	0.000000	0	91.01
91.02	09102 DIABETES CENTER	0	415,900	0.000000	0.000000	0	91.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	7,316,011	0.000000	0.000000	600,151	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0.000000	0.000000	0	94.00
200.00	Total (lines 50-199)	883,832	947,635,692			180,158,181	200.00



APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140213	Period: From 10/01/2013 To 09/30/2014	Worksheet D Part IV Date/Time Prepared: 2/25/2015 8:07 am
	Title XVIII	Hospital	PPS

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		11.00	12.00	13.00	
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	5,622	16,715,520	4,664	50.00
51.00	05100 RECOVERY ROOM	0	1,576,767	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	14	819	4	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	32,136,690	0	54.00
54.01	05401 ULTRASOUND	0	3,013,205	0	54.01
57.00	05700 CT SCAN	0	14,772,649	0	57.00
58.00	05800 MRI	0	4,644,940	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000 LABORATORY	0	6,479,426	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	776,224	0	63.00
65.00	06500 RESPIRATORY THERAPY	17,540	668,755	1,103	65.00
65.01	06501 SLEEP LAB	0	712,368	0	65.01
66.00	06600 PHYSICAL THERAPY	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	11,130	2,373,461	4,248	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	500,578	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	7,122,304	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	2,782,716	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	4,718,115	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800 RURAL HEALTH CLINIC	0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00	09000 CLINIC	0	592,369	0	90.00
90.01	09001 HOMER GLEN LAB	0	1,150,552	0	90.01
90.02	09002 HOMER GLEN FEC	0	1,020,025	0	90.02
90.03	09003 WOMEN'S HEALTH	0	641,374	0	90.03
91.00	09100 EMERGENCY	116,659	8,192,419	77,328	91.00
91.01	09101 OP MENTAL HEALTH	0	127,330	0	91.01
91.02	09102 DIABETES CENTER	0	0	0	91.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	1,798,457	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0	94.00
200.00	Total (lines 50-199)	150,965	112,517,063	87,347	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 140213	Period: From 10/01/2013 To 09/30/2014	Worksheet D Part V Date/Time Prepared: 2/25/2015 8:07 am
		Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs			
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)			
	1.00	2.00	3.00	4.00	5.00			
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0.204940	16,715,520	0	0	3,425,679	50.00
51.00	05100	RECOVERY ROOM	0.111982	1,576,767	0	0	176,570	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.706686	819	0	0	579	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.182557	32,136,690	0	0	5,866,778	54.00
54.01	05401	ULTRASOUND	0.105967	3,013,205	0	0	319,300	54.01
57.00	05700	CT SCAN	0.038435	14,772,649	0	0	567,787	57.00
58.00	05800	MRI	0.080082	4,644,940	0	0	371,976	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.081055	6,479,426	1,876	0	525,190	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.280339	776,224	0	0	217,606	63.00
65.00	06500	RESPIRATORY THERAPY	0.146237	668,755	343	0	97,797	65.00
65.01	06501	SLEEP LAB	0.177673	712,368	0	0	126,569	65.01
66.00	06600	PHYSICAL THERAPY	0.344137	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.207264	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.121645	2,373,461	0	0	288,720	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.252884	500,578	0	0	126,588	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.529844	7,122,304	0	0	3,773,710	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.573607	2,782,716	58,580	0	1,596,185	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.324595	4,718,115	0	42,471	1,531,477	73.00
74.00	07400	RENAL DIALYSIS	0.353186	0	0	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
90.00	09000	CLINIC	1.450415	592,369	0	0	859,181	90.00
90.01	09001	HOMER GLEN LAB	0.232664	1,150,552	0	0	267,692	90.01
90.02	09002	HOMER GLEN FEC	0.219629	1,020,025	0	0	224,027	90.02
90.03	09003	WOMEN'S HEALTH	0.388295	641,374	0	0	249,042	90.03
91.00	09100	EMERGENCY	0.215490	8,192,419	0	0	1,765,384	91.00
91.01	09101	OP MENTAL HEALTH	0.559178	127,330	0	0	71,200	91.01
91.02	09102	DIABETES CENTER	0.977975	0	0	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.900151	1,798,457	0	0	1,618,883	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
94.00	09400	HOME PROGRAM DIALYSIS	0.000000		0			94.00
200.00		Subtotal (see instructions)		112,517,063	60,799	42,471	24,067,920	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		112,517,063	60,799	42,471	24,067,920	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 140213	Period: From 10/01/2013 To 09/30/2014	Worksheet D Part V Date/Time Prepared: 2/25/2015 8:07 am
	Title XVIII	Hospital	PPS

Cost Center Description	Costs		Hospital	PPS
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
<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
54.01 05401 ULTRASOUND	0	0		54.01
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	152	0		60.00
60.01 06001 BLOOD LABORATORY	0	0		60.01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
65.00 06500 RESPIRATORY THERAPY	50	0		65.00
65.01 06501 SLEEP LAB	0	0		65.01
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	33,602	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	13,786		73.00
74.00 07400 RENAL DIALYSIS	0	0		74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00 08800 RURAL HEALTH CLINIC	0	0		88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00 09000 CLINIC	0	0		90.00
90.01 09001 HOMER GLEN LAB	0	0		90.01
90.02 09002 HOMER GLEN FEC	0	0		90.02
90.03 09003 WOMEN'S HEALTH	0	0		90.03
91.00 09100 EMERGENCY	0	0		91.00
91.01 09101 OP MENTAL HEALTH	0	0		91.01
91.02 09102 DIABETES CENTER	0	0		91.02
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
94.00 09400 HOME PROGRAM DIALYSIS	0	0		94.00
200.00	Subtotal (see instructions)	33,804	13,786	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 +/- line 201)	33,804	13,786	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 140213 Component CCN: 14S213		Period: From 10/01/2013 To 09/30/2014		Worksheet D Part II Date/Time Prepared: 2/25/2015 8:07 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	6,663,535	159,308,157	0.041828	19,022	796	50.00
51.00	05100	RECOVERY ROOM	401,131	23,153,089	0.017325	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	610,420	8,575,760	0.071180	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,517,918	144,341,469	0.031300	11,596	363	54.00
54.01	05401	ULTRASOUND	469,777	24,246,223	0.019375	13,492	261	54.01
57.00	05700	CT SCAN	736,883	87,953,743	0.008378	15,482	130	57.00
58.00	05800	MRI	575,739	28,438,108	0.020245	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	804,278	151,405,077	0.005312	232,382	1,234	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	123,038	8,287,596	0.014846	52,244	776	63.00
65.00	06500	RESPIRATORY THERAPY	316,803	21,104,785	0.015011	30,471	457	65.00
65.01	06501	SLEEP LAB	52,641	2,873,576	0.018319	0	0	65.01
66.00	06600	PHYSICAL THERAPY	239,949	11,214,519	0.021396	4,401	94	66.00
67.00	06700	OCCUPATIONAL THERAPY	127,727	12,441,524	0.010266	3,191	33	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	261,333	17,795,049	0.014686	13,330	196	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	97,883	2,456,683	0.039844	1,190	47	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,486,375	33,091,377	0.044917	3,829	172	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	930,792	34,742,600	0.026791	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,989,173	64,880,336	0.030659	184,618	5,660	73.00
74.00	07400	RENAL DIALYSIS	258,355	3,522,200	0.073350	7,916	581	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	63,621	854,492	0.074455	837	62	90.00
90.01	09001	HOMER GLEN LAB	65,631	5,007,707	0.013106	3,483	46	90.01
90.02	09002	HOMER GLEN FEC	134,747	8,865,598	0.015199	2,191	33	90.02
90.03	09003	WOMEN'S HEALTH	380,836	5,547,576	0.068649	0	0	90.03
91.00	09100	EMERGENCY	2,977,674	77,968,031	0.038191	216,914	8,284	91.00
91.01	09101	OP MENTAL HEALTH	221,667	1,828,506	0.121228	0	0	91.01
91.02	09102	DIABETES CENTER	19,917	415,900	0.047889	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	7,316,011	0.000000	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0.000000	0	0	94.00
200.00		Total (lines 50-199)	24,527,843	947,635,692		816,589	19,225	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140213 Component CCN: 14S213	Period: From 10/01/2013 To 09/30/2014	Worksheet D Part IV Date/Time Prepared: 2/25/2015 8:07 am
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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	44,409	0	44,409	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	36,821	0	36,821	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	34,831	0	34,831	65.00
65.01	06501	SLEEP LAB	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	31,845	0	31,845	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	735,926	0	735,926	91.00
91.01	09101	OP MENTAL HEALTH	0	0	0	0	0	91.01
91.02	09102	DIABETES CENTER	0	0	0	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
200.00		Total (lines 50-199)	0	0	883,832	0	883,832	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140213 Component CCN: 14S213	Period: From 10/01/2013 To 09/30/2014	Worksheet D Part IV Date/Time Prepared: 2/25/2015 8:07 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	44,409	159,308,157	0.000279	0.000279	19,022	50.00
51.00 05100 RECOVERY ROOM	0	23,153,089	0.000000	0.000000	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	36,821	8,575,760	0.004294	0.004294	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	144,341,469	0.000000	0.000000	11,596	54.00
54.01 05401 ULTRASOUND	0	24,246,223	0.000000	0.000000	13,492	54.01
57.00 05700 CT SCAN	0	87,953,743	0.000000	0.000000	15,482	57.00
58.00 05800 MRI	0	28,438,108	0.000000	0.000000	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00 06000 LABORATORY	0	151,405,077	0.000000	0.000000	232,382	60.00
60.01 06001 BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	8,287,596	0.000000	0.000000	52,244	63.00
65.00 06500 RESPIRATORY THERAPY	34,831	21,104,785	0.001650	0.001650	30,471	65.00
65.01 06501 SLEEP LAB	0	2,873,576	0.000000	0.000000	0	65.01
66.00 06600 PHYSICAL THERAPY	0	11,214,519	0.000000	0.000000	4,401	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	12,441,524	0.000000	0.000000	3,191	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00 06900 ELECTROCARDIOLOGY	31,845	17,795,049	0.001790	0.001790	13,330	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	2,456,683	0.000000	0.000000	1,190	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	33,091,377	0.000000	0.000000	3,829	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	34,742,600	0.000000	0.000000	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	64,880,336	0.000000	0.000000	184,618	73.00
74.00 07400 RENAL DIALYSIS	0	3,522,200	0.000000	0.000000	7,916	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800 RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00 09000 CLINIC	0	854,492	0.000000	0.000000	837	90.00
90.01 09001 HOMER GLEN LAB	0	5,007,707	0.000000	0.000000	3,483	90.01
90.02 09002 HOMER GLEN FEC	0	8,865,598	0.000000	0.000000	2,191	90.02
90.03 09003 WOMEN'S HEALTH	0	5,547,576	0.000000	0.000000	0	90.03
91.00 09100 EMERGENCY	735,926	77,968,031	0.009439	0.009439	216,914	91.00
91.01 09101 OP MENTAL HEALTH	0	1,828,506	0.000000	0.000000	0	91.01
91.02 09102 DIABETES CENTER	0	415,900	0.000000	0.000000	0	91.02
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	7,316,011	0.000000	0.000000	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0.000000	0.000000	0	94.00
200.00 Total (lines 50-199)	883,832	947,635,692			816,589	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140213 Component CCN: 14S213	Period: From 10/01/2013 To 09/30/2014	Worksheet D Part IV Date/Time Prepared: 2/25/2015 8:07 am
Title XVII		Subprovider - IPF	PPS

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		11.00	12.00	13.00	
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	5	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
54.01	05401 ULTRASOUND	0	0	0	54.01
57.00	05700 CT SCAN	0	0	0	57.00
58.00	05800 MRI	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	50	0	0	65.00
65.01	06501 SLEEP LAB	0	0	0	65.01
66.00	06600 PHYSICAL THERAPY	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	24	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800 RURAL HEALTH CLINIC	0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00	09000 CLINIC	0	0	0	90.00
90.01	09001 HOMER GLEN LAB	0	0	0	90.01
90.02	09002 HOMER GLEN FEC	0	0	0	90.02
90.03	09003 WOMEN'S HEALTH	0	0	0	90.03
91.00	09100 EMERGENCY	2,047	0	0	91.00
91.01	09101 OP MENTAL HEALTH	0	0	0	91.01
91.02	09102 DIABETES CENTER	0	0	0	91.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0	94.00
200.00	Total (lines 50-199)	2,126	0	0	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 140213		Period: From 10/01/2013 To 09/30/2014		Worksheet D Part II Date/Time Prepared: 2/25/2015 8:07 am		
		Component CCN: 14T213		Title XVIII		Subprovider - IRF		
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	6,663,535	159,308,157	0.041828	159,564	6,674	50.00
51.00	05100	RECOVERY ROOM	401,131	23,153,089	0.017325	595	10	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	610,420	8,575,760	0.071180	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,517,918	144,341,469	0.031300	177,732	5,563	54.00
54.01	05401	ULTRASOUND	469,777	24,246,223	0.019375	92,932	1,801	54.01
57.00	05700	CT SCAN	736,883	87,953,743	0.008378	183,377	1,536	57.00
58.00	05800	MRI	575,739	28,438,108	0.020245	47,842	969	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	804,278	151,405,077	0.005312	756,171	4,017	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	123,038	8,287,596	0.014846	221,345	3,286	63.00
65.00	06500	RESPIRATORY THERAPY	316,803	21,104,785	0.015011	530,622	7,965	65.00
65.01	06501	SLEEP LAB	52,641	2,873,576	0.018319	0	0	65.01
66.00	06600	PHYSICAL THERAPY	239,949	11,214,519	0.021396	2,241,663	47,963	66.00
67.00	06700	OCCUPATIONAL THERAPY	127,727	12,441,524	0.010266	2,124,672	21,812	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	261,333	17,795,049	0.014686	32,874	483	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	97,883	2,456,683	0.039844	3,034	121	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,486,375	33,091,377	0.044917	204,707	9,195	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	930,792	34,742,600	0.026791	4,508	121	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,989,173	64,880,336	0.030659	1,018,905	31,239	73.00
74.00	07400	RENAL DIALYSIS	258,355	3,522,200	0.073350	107,664	7,897	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	63,621	854,492	0.074455	1,530	114	90.00
90.01	09001	HOMER GLEN LAB	65,631	5,007,707	0.013106	11,705	153	90.01
90.02	09002	HOMER GLEN FEC	134,747	8,865,598	0.015199	0	0	90.02
90.03	09003	WOMEN'S HEALTH	380,836	5,547,576	0.068649	0	0	90.03
91.00	09100	EMERGENCY	2,977,674	77,968,031	0.038191	82	3	91.00
91.01	09101	OP MENTAL HEALTH	221,667	1,828,506	0.121228	0	0	91.01
91.02	09102	DIABETES CENTER	19,917	415,900	0.047889	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	7,316,011	0.000000	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0.000000	0	0	94.00
200.00		Total (lines 50-199)	24,527,843	947,635,692		7,921,524	150,922	200.00



APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140213 Component CCN: 14T213	Period: From 10/01/2013 To 09/30/2014	Worksheet D Part IV Date/Time Prepared: 2/25/2015 8:07 am
	Title XVIII	Subprovider - IRF	PPS

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	44,409	0	44,409	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	36,821	0	36,821	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401 ULTRASOUND	0	0	0	0	0	54.01
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MRI	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0	0	34,831	0	34,831	65.00
65.01	06501 SLEEP LAB	0	0	0	0	0	65.01
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	31,845	0	31,845	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000 CLINIC	0	0	0	0	0	90.00
90.01	09001 HOMER GLEN LAB	0	0	0	0	0	90.01
90.02	09002 HOMER GLEN FEC	0	0	0	0	0	90.02
90.03	09003 WOMEN'S HEALTH	0	0	0	0	0	90.03
91.00	09100 EMERGENCY	0	0	735,926	0	735,926	91.00
91.01	09101 OP MENTAL HEALTH	0	0	0	0	0	91.01
91.02	09102 DIABETES CENTER	0	0	0	0	0	91.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
200.00	Total (lines 50-199)	0	0	883,832	0	883,832	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 140213 Component CCN: 14T213		Period: From 10/01/2013 To 09/30/2014		Worksheet D Part IV Date/Time Prepared: 2/25/2015 8:07 am		
				Title XVIII		Subprovider - IRF	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	44,409	159,308,157	0.000279	0.000279	159,564	50.00
51.00	05100	RECOVERY ROOM	0	23,153,089	0.000000	0.000000	595	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	36,821	8,575,760	0.004294	0.004294	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	144,341,469	0.000000	0.000000	177,732	54.00
54.01	05401	ULTRASOUND	0	24,246,223	0.000000	0.000000	92,932	54.01
57.00	05700	CT SCAN	0	87,953,743	0.000000	0.000000	183,377	57.00
58.00	05800	MRI	0	28,438,108	0.000000	0.000000	47,842	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	151,405,077	0.000000	0.000000	756,171	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	8,287,596	0.000000	0.000000	221,345	63.00
65.00	06500	RESPIRATORY THERAPY	34,831	21,104,785	0.001650	0.001650	530,622	65.00
65.01	06501	SLEEP LAB	0	2,873,576	0.000000	0.000000	0	65.01
66.00	06600	PHYSICAL THERAPY	0	11,214,519	0.000000	0.000000	2,241,663	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	12,441,524	0.000000	0.000000	2,124,672	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	31,845	17,795,049	0.001790	0.001790	32,874	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2,456,683	0.000000	0.000000	3,034	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	33,091,377	0.000000	0.000000	204,707	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	34,742,600	0.000000	0.000000	4,508	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	64,880,336	0.000000	0.000000	1,018,905	73.00
74.00	07400	RENAL DIALYSIS	0	3,522,200	0.000000	0.000000	107,664	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	09000	CLINIC	0	854,492	0.000000	0.000000	1,530	90.00
90.01	09001	HOMER GLEN LAB	0	5,007,707	0.000000	0.000000	11,705	90.01
90.02	09002	HOMER GLEN FEC	0	8,865,598	0.000000	0.000000	0	90.02
90.03	09003	WOMEN'S HEALTH	0	5,547,576	0.000000	0.000000	0	90.03
91.00	09100	EMERGENCY	735,926	77,968,031	0.009439	0.009439	82	91.00
91.01	09101	OP MENTAL HEALTH	0	1,828,506	0.000000	0.000000	0	91.01
91.02	09102	DIABETES CENTER	0	415,900	0.000000	0.000000	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	7,316,011	0.000000	0.000000	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0.000000	0.000000	0	94.00
200.00		Total (lines 50-199)	883,832	947,635,692			7,921,524	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140213 Component CCN: 14T213	Period: From 10/01/2013 To 09/30/2014	Worksheet D Part IV Date/Time Prepared: 2/25/2015 8:07 am
Title XVIIII		Subprovider - IRF	PPS

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		11.00	12.00	13.00	
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	45	3,154	1	50.00
51.00	05100 RECOVERY ROOM	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	17,996	0	54.00
54.01	05401 ULTRASOUND	0	2,869	0	54.01
57.00	05700 CT SCAN	0	9,490	0	57.00
58.00	05800 MRI	0	52	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000 LABORATORY	0	1,492	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	876	156	0	65.00
65.01	06501 SLEEP LAB	0	0	0	65.01
66.00	06600 PHYSICAL THERAPY	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	59	3,596	6	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,860	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	2,652	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800 RURAL HEALTH CLINIC	0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00	09000 CLINIC	0	510	0	90.00
90.01	09001 HOMER GLEN LAB	0	0	0	90.01
90.02	09002 HOMER GLEN FEC	0	2,577	0	90.02
90.03	09003 WOMEN'S HEALTH	0	388	0	90.03
91.00	09100 EMERGENCY	1	20,701	195	91.00
91.01	09101 OP MENTAL HEALTH	0	0	0	91.01
91.02	09102 DIABETES CENTER	0	0	0	91.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0	94.00
200.00	Total (lines 50-199)	981	68,493	202	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 140213	Period: From 10/01/2013 To 09/30/2014	Worksheet D Part V Date/Time Prepared: 2/25/2015 8:07 am			
		Component CCN: 14T213	Title XVIII	Subprovider - IRF	PPS		
Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges			Costs		
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
	1.00	2.00	3.00	4.00	5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0.204940	3,154	0	0	646	50.00
51.00	05100 RECOVERY ROOM	0.111982	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.706686	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.182557	17,996	0	0	3,285	54.00
54.01	05401 ULTRASOUND	0.105967	2,869	0	0	304	54.01
57.00	05700 CT SCAN	0.038435	9,490	0	0	365	57.00
58.00	05800 MRI	0.080082	52	0	0	4	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000 LABORATORY	0.081055	1,492	0	0	121	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.280339	0	0	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0.146237	156	0	0	23	65.00
65.01	06501 SLEEP LAB	0.177673	0	0	0	0	65.01
66.00	06600 PHYSICAL THERAPY	0.344137	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.207264	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.121645	3,596	0	0	437	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.252884	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.529844	2,860	0	0	1,515	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.573607	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.324595	2,652	0	224	861	73.00
74.00	07400 RENAL DIALYSIS	0.353186	0	0	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0.000000				0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
90.00	09000 CLINIC	1.450415	510	0	0	740	90.00
90.01	09001 HOMER GLEN LAB	0.232664	0	0	0	0	90.01
90.02	09002 HOMER GLEN FEC	0.219629	2,577	0	0	566	90.02
90.03	09003 WOMEN'S HEALTH	0.388295	388	0	0	151	90.03
91.00	09100 EMERGENCY	0.215490	20,701	0	0	4,461	91.00
91.01	09101 OP MENTAL HEALTH	0.559178	0	0	0	0	91.01
91.02	09102 DIABETES CENTER	0.977975	0	0	0	0	91.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.900151	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
94.00	09400 HOME PROGRAM DIALYSIS	0.000000		0			94.00
200.00	Subtotal (see instructions)		68,493	0	224	13,479	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00	Net Charges (line 200 +/- line 201)		68,493	0	224	13,479	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 140213 Component CCN: 14T213	Period: From 10/01/2013 To 09/30/2014	Worksheet D Part V Date/Time Prepared: 2/25/2015 8:07 am
	Title XVIII	Subprovider - IRF	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
<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
54.01 05401 ULTRASOUND	0	0		54.01
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
60.01 06001 BLOOD LABORATORY	0	0		60.01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
65.01 06501 SLEEP LAB	0	0		65.01
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	73		73.00
74.00 07400 RENAL DIALYSIS	0	0		74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00 08800 RURAL HEALTH CLINIC	0	0		88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00 09000 CLINIC	0	0		90.00
90.01 09001 HOMER GLEN LAB	0	0		90.01
90.02 09002 HOMER GLEN FEC	0	0		90.02
90.03 09003 WOMEN'S HEALTH	0	0		90.03
91.00 09100 EMERGENCY	0	0		91.00
91.01 09101 OP MENTAL HEALTH	0	0		91.01
91.02 09102 DIABETES CENTER	0	0		91.02
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
94.00 09400 HOME PROGRAM DIALYSIS	0	0		94.00
200.00	Subtotal (see instructions)	0	73	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 +/- line 201)	0	73	202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 140213	Period: From 10/01/2013 To 09/30/2014	Worksheet D Part I Date/Time Prepared: 2/25/2015 8:07 am
		Title XIX	Hospital	PPS

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	11,180,118	0	11,180,118	61,775	180.98	30.00
31.00	INTENSIVE CARE UNIT	2,083,908		2,083,908	5,843	356.65	31.00
40.00	SUBPROVIDER - IPF	943,248	0	943,248	4,575	206.17	40.00
41.00	SUBPROVIDER - IRF	1,767,275	0	1,767,275	7,472	236.52	41.00
42.00	SUBPROVIDER	0	0	0	0	0.00	42.00
43.00	NURSERY	3,141,397		3,141,397	6,375	492.77	43.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
45.00	NURSING FACILITY	0		0	0	0.00	45.00
200.00	Total (lines 30-199)	19,115,946		19,115,946	86,040		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	8,416	1,523,128				
31.00	INTENSIVE CARE UNIT	908	323,838				
40.00	SUBPROVIDER - IPF	951	196,068				
41.00	SUBPROVIDER - IRF	196	46,358				
42.00	SUBPROVIDER	0	0				
43.00	NURSERY	991	488,335				
44.00	SKILLED NURSING FACILITY	0	0				
45.00	NURSING FACILITY	0	0				
200.00	Total (lines 30-199)	11,462	2,577,727				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 140213

Period:  
From 10/01/2013  
To 09/30/2014

Worksheet D  
Part II  
Date/Time Prepared:  
2/25/2015 8:07 am

Cost Center Description		Title XIX			Hospital	PPS		
		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	6,663,535	159,308,157	0.041828	0	0	50.00
51.00	05100	RECOVERY ROOM	401,131	23,153,089	0.017325	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	610,420	8,575,760	0.071180	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,517,918	144,341,469	0.031300	0	0	54.00
54.01	05401	ULTRASOUND	469,777	24,246,223	0.019375	0	0	54.01
57.00	05700	CT SCAN	736,883	87,953,743	0.008378	0	0	57.00
58.00	05800	MRI	575,739	28,438,108	0.020245	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	804,278	151,405,077	0.005312	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	123,038	8,287,596	0.014846	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	316,803	21,104,785	0.015011	0	0	65.00
65.01	06501	SLEEP LAB	52,641	2,873,576	0.018319	0	0	65.01
66.00	06600	PHYSICAL THERAPY	239,949	11,214,519	0.021396	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	127,727	12,441,524	0.010266	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	261,333	17,795,049	0.014686	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	97,883	2,456,683	0.039844	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,486,375	33,091,377	0.044917	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	930,792	34,742,600	0.026791	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,989,173	64,880,336	0.030659	0	0	73.00
74.00	07400	RENAL DIALYSIS	258,355	3,522,200	0.073350	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	63,621	854,492	0.074455	0	0	90.00
90.01	09001	HOMER GLEN LAB	65,631	5,007,707	0.013106	0	0	90.01
90.02	09002	HOMER GLEN FEC	134,747	8,865,598	0.015199	0	0	90.02
90.03	09003	WOMEN'S HEALTH	380,836	5,547,576	0.068649	0	0	90.03
91.00	09100	EMERGENCY	2,977,674	77,968,031	0.038191	0	0	91.00
91.01	09101	OP MENTAL HEALTH	221,667	1,828,506	0.121228	0	0	91.01
91.02	09102	DIABETES CENTER	19,917	415,900	0.047889	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,176,561	7,316,011	0.160820	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0.000000	0	0	94.00
200.00		Total (lines 50-199)	25,704,404	947,635,692		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 140213	Period: From 10/01/2013 To 09/30/2014	Worksheet D Part III Date/Time Prepared: 2/25/2015 8:07 am
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Cost Center Description			Title XIX		Hospital		PPS	
Cost Center Description			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	70,657	0	0	70,657	31.00
40.00	04000	SUBPROVIDER - I/PF	0	20,898	0	0	20,898	40.00
41.00	04100	SUBPROVIDER - I/RF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
200.00		Total (lines 30-199)	0	91,555	0	0	91,555	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	61,775	0.00	8,416	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	5,843	12.09	908	10,978	0	31.00
40.00	04000	SUBPROVIDER - I/PF	4,575	4.57	951	4,346	0	40.00
41.00	04100	SUBPROVIDER - I/RF	7,472	0.00	196	0	0	41.00
42.00	04200	SUBPROVIDER	0	0.00	0	0	0	42.00
43.00	04300	NURSERY	6,375	0.00	991	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0.00	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0.00	0	0	0	45.00
200.00		Total (lines 30-199)	86,040		11,462	15,324		200.00



APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140213	Period: From 10/01/2013 To 09/30/2014	Worksheet D Part IV Date/Time Prepared: 2/25/2015 8:07 am
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Cost Center Description	Title XIX				Hospital	PPS	Total Cost (sum of col 1 through col . 4)	
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost				
	1.00	2.00	3.00	4.00		5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00 05000 OPERATING ROOM	0	0	44,409	0		44,409	50.00	
51.00 05100 RECOVERY ROOM	0	0	0	0		0	51.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	36,821	0		36,821	52.00	
53.00 05300 ANESTHESIOLOGY	0	0	0	0		0	53.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0		0	54.00	
54.01 05401 ULTRASOUND	0	0	0	0		0	54.01	
57.00 05700 CT SCAN	0	0	0	0		0	57.00	
58.00 05800 MRI	0	0	0	0		0	58.00	
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0		0	59.00	
60.00 06000 LABORATORY	0	0	0	0		0	60.00	
60.01 06001 BLOOD LABORATORY	0	0	0	0		0	60.01	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0		0	63.00	
65.00 06500 RESPIRATORY THERAPY	0	0	34,831	0		34,831	65.00	
65.01 06501 SLEEP LAB	0	0	0	0		0	65.01	
66.00 06600 PHYSICAL THERAPY	0	0	0	0		0	66.00	
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0		0	67.00	
68.00 06800 SPEECH PATHOLOGY	0	0	0	0		0	68.00	
69.00 06900 ELECTROCARDIOLOGY	0	0	31,845	0		31,845	69.00	
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0		0	70.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0		0	71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0		0	72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0		0	73.00	
74.00 07400 RENAL DIALYSIS	0	0	0	0		0	74.00	
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00 08800 RURAL HEALTH CLINIC	0	0	0	0		0	88.00	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0		0	89.00	
90.00 09000 CLINIC	0	0	0	0		0	90.00	
90.01 09001 HOMER GLEN LAB	0	0	0	0		0	90.01	
90.02 09002 HOMER GLEN FEC	0	0	0	0		0	90.02	
90.03 09003 WOMEN'S HEALTH	0	0	0	0		0	90.03	
91.00 09100 EMERGENCY	0	0	735,926	0		735,926	91.00	
91.01 09101 OP MENTAL HEALTH	0	0	0	0		0	91.01	
91.02 09102 DIABETES CENTER	0	0	0	0		0	91.02	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0		0	92.00	
<b>OTHER REIMBURSABLE COST CENTERS</b>								
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0	0		0	94.00	
200.00 Total (lines 50-199)	0	0	883,832	0		883,832	200.00	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140213

Period:  
From 10/01/2013  
To 09/30/2014

Worksheet D  
Part IV  
Date/Time Prepared:  
2/25/2015 8:07 am

Cost Center Description		Title XIX			Hospital	PPS		
		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	44,409	159,308,157	0.000279	0.000279	0	50.00
51.00	05100	RECOVERY ROOM	0	23,153,089	0.000000	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	36,821	8,575,760	0.004294	0.004294	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	144,341,469	0.000000	0.000000	0	54.00
54.01	05401	ULTRASOUND	0	24,246,223	0.000000	0.000000	0	54.01
57.00	05700	CT SCAN	0	87,953,743	0.000000	0.000000	0	57.00
58.00	05800	MRI	0	28,438,108	0.000000	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	151,405,077	0.000000	0.000000	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	8,287,596	0.000000	0.000000	0	63.00
65.00	06500	RESPIRATORY THERAPY	34,831	21,104,785	0.001650	0.001650	0	65.00
65.01	06501	SLEEP LAB	0	2,873,576	0.000000	0.000000	0	65.01
66.00	06600	PHYSICAL THERAPY	0	11,214,519	0.000000	0.000000	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	12,441,524	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	31,845	17,795,049	0.001790	0.001790	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2,456,683	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	33,091,377	0.000000	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	34,742,600	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	64,880,336	0.000000	0.000000	0	73.00
74.00	07400	RENAL DIALYSIS	0	3,522,200	0.000000	0.000000	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	09000	CLINIC	0	854,492	0.000000	0.000000	0	90.00
90.01	09001	HOMER GLEN LAB	0	5,007,707	0.000000	0.000000	0	90.01
90.02	09002	HOMER GLEN FEC	0	8,865,598	0.000000	0.000000	0	90.02
90.03	09003	WOMEN'S HEALTH	0	5,547,576	0.000000	0.000000	0	90.03
91.00	09100	EMERGENCY	735,926	77,968,031	0.009439	0.009439	0	91.00
91.01	09101	OP MENTAL HEALTH	0	1,828,506	0.000000	0.000000	0	91.01
91.02	09102	DIABETES CENTER	0	415,900	0.000000	0.000000	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	7,316,011	0.000000	0.000000	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0.000000	0.000000	0	94.00
200.00		Total (lines 50-199)	883,832	947,635,692			0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140213	Period: From 10/01/2013 To 09/30/2014	Worksheet D Part IV Date/Time Prepared: 2/25/2015 8:07 am
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Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	Hospital	PPS
		11.00	12.00	13.00		
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	0	0	0		50.00
51.00	05100 RECOVERY ROOM	0	0	0		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53.00	05300 ANESTHESIOLOGY	0	0	0		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0		54.00
54.01	05401 ULTRASOUND	0	0	0		54.01
57.00	05700 CT SCAN	0	0	0		57.00
58.00	05800 MRI	0	0	0		58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000 LABORATORY	0	0	0		60.00
60.01	06001 BLOOD LABORATORY	0	0	0		60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0		63.00
65.00	06500 RESPIRATORY THERAPY	0	0	0		65.00
65.01	06501 SLEEP LAB	0	0	0		65.01
66.00	06600 PHYSICAL THERAPY	0	0	0		66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0		67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0		73.00
74.00	07400 RENAL DIALYSIS	0	0	0		74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800 RURAL HEALTH CLINIC	0	0	0		88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	09000 CLINIC	0	0	0		90.00
90.01	09001 HOMER GLEN LAB	0	0	0		90.01
90.02	09002 HOMER GLEN FEC	0	0	0		90.02
90.03	09003 WOMEN'S HEALTH	0	0	0		90.03
91.00	09100 EMERGENCY	0	0	0		91.00
91.01	09101 OP MENTAL HEALTH	0	0	0		91.01
91.02	09102 DIABETES CENTER	0	0	0		91.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0		94.00
200.00	Total (lines 50-199)	0	0	0		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 140213 Component CCN: 14S213		Period: From 10/01/2013 To 09/30/2014		Worksheet D Part II Date/Time Prepared: 2/25/2015 8:07 am	
		Title XIX		Subprovider - IPF		PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	6,663,535	159,308,157	0.041828	0	50.00
51.00	05100	RECOVERY ROOM	401,131	23,153,089	0.017325	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	610,420	8,575,760	0.071180	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,517,918	144,341,469	0.031300	0	54.00
54.01	05401	ULTRASOUND	469,777	24,246,223	0.019375	0	54.01
57.00	05700	CT SCAN	736,883	87,953,743	0.008378	0	57.00
58.00	05800	MRI	575,739	28,438,108	0.020245	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	59.00
60.00	06000	LABORATORY	804,278	151,405,077	0.005312	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	123,038	8,287,596	0.014846	0	63.00
65.00	06500	RESPIRATORY THERAPY	316,803	21,104,785	0.015011	0	65.00
65.01	06501	SLEEP LAB	52,641	2,873,576	0.018319	0	65.01
66.00	06600	PHYSICAL THERAPY	239,949	11,214,519	0.021396	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	127,727	12,441,524	0.010266	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	261,333	17,795,049	0.014686	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	97,883	2,456,683	0.039844	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,486,375	33,091,377	0.044917	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	930,792	34,742,600	0.026791	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,989,173	64,880,336	0.030659	0	73.00
74.00	07400	RENAL DIALYSIS	258,355	3,522,200	0.073350	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	89.00
90.00	09000	CLINIC	63,621	854,492	0.074455	0	90.00
90.01	09001	HOMER GLEN LAB	65,631	5,007,707	0.013106	0	90.01
90.02	09002	HOMER GLEN FEC	134,747	8,865,598	0.015199	0	90.02
90.03	09003	WOMEN'S HEALTH	380,836	5,547,576	0.068649	0	90.03
91.00	09100	EMERGENCY	2,977,674	77,968,031	0.038191	0	91.00
91.01	09101	OP MENTAL HEALTH	221,667	1,828,506	0.121228	0	91.01
91.02	09102	DIABETES CENTER	19,917	415,900	0.047889	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	7,316,011	0.000000	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0.000000	0	94.00
200.00		Total (lines 50-199)	24,527,843	947,635,692		0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140213 Component CCN: 14S213	Period: From 10/01/2013 To 09/30/2014	Worksheet D Part IV Date/Time Prepared: 2/25/2015 8:07 am
	Title XIX	Subprovider - IPF	PPS

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	44,409	0	44,409	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	36,821	0	36,821	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401 ULTRASOUND	0	0	0	0	0	54.01
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MRI	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0	0	34,831	0	34,831	65.00
65.01	06501 SLEEP LAB	0	0	0	0	0	65.01
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	31,845	0	31,845	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000 CLINIC	0	0	0	0	0	90.00
90.01	09001 HOMER GLEN LAB	0	0	0	0	0	90.01
90.02	09002 HOMER GLEN FEC	0	0	0	0	0	90.02
90.03	09003 WOMEN'S HEALTH	0	0	0	0	0	90.03
91.00	09100 EMERGENCY	0	0	735,926	0	735,926	91.00
91.01	09101 OP MENTAL HEALTH	0	0	0	0	0	91.01
91.02	09102 DIABETES CENTER	0	0	0	0	0	91.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
200.00	Total (lines 50-199)	0	0	883,832	0	883,832	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140213 Component CCN: 14S213	Period: From 10/01/2013 To 09/30/2014	Worksheet D Part IV Date/Time Prepared: 2/25/2015 8:07 am
Title XIX		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	44,409	159,308,157	0.000279	0.000279	0 50.00
51.00 05100 RECOVERY ROOM	0	23,153,089	0.000000	0.000000	0 51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	36,821	8,575,760	0.004294	0.004294	0 52.00
53.00 05300 ANESTHESIOLOGY	0	0	0.000000	0.000000	0 53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	144,341,469	0.000000	0.000000	0 54.00
54.01 05401 ULTRASOUND	0	24,246,223	0.000000	0.000000	0 54.01
57.00 05700 CT SCAN	0	87,953,743	0.000000	0.000000	0 57.00
58.00 05800 MRI	0	28,438,108	0.000000	0.000000	0 58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0 59.00
60.00 06000 LABORATORY	0	151,405,077	0.000000	0.000000	0 60.00
60.01 06001 BLOOD LABORATORY	0	0	0.000000	0.000000	0 60.01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	8,287,596	0.000000	0.000000	0 63.00
65.00 06500 RESPIRATORY THERAPY	34,831	21,104,785	0.001650	0.001650	0 65.00
65.01 06501 SLEEP LAB	0	2,873,576	0.000000	0.000000	0 65.01
66.00 06600 PHYSICAL THERAPY	0	11,214,519	0.000000	0.000000	0 66.00
67.00 06700 OCCUPATIONAL THERAPY	0	12,441,524	0.000000	0.000000	0 67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0.000000	0.000000	0 68.00
69.00 06900 ELECTROCARDIOLOGY	31,845	17,795,049	0.001790	0.001790	0 69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	2,456,683	0.000000	0.000000	0 70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	33,091,377	0.000000	0.000000	0 71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	34,742,600	0.000000	0.000000	0 72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	64,880,336	0.000000	0.000000	0 73.00
74.00 07400 RENAL DIALYSIS	0	3,522,200	0.000000	0.000000	0 74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00 08800 RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0 88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0 89.00
90.00 09000 CLINIC	0	854,492	0.000000	0.000000	0 90.00
90.01 09001 HOMER GLEN LAB	0	5,007,707	0.000000	0.000000	0 90.01
90.02 09002 HOMER GLEN FEC	0	8,865,598	0.000000	0.000000	0 90.02
90.03 09003 WOMEN'S HEALTH	0	5,547,576	0.000000	0.000000	0 90.03
91.00 09100 EMERGENCY	735,926	77,968,031	0.009439	0.009439	0 91.00
91.01 09101 OP MENTAL HEALTH	0	1,828,506	0.000000	0.000000	0 91.01
91.02 09102 DIABETES CENTER	0	415,900	0.000000	0.000000	0 91.02
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	7,316,011	0.000000	0.000000	0 92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0.000000	0.000000	0 94.00
200.00 Total (lines 50-199)	883,832	947,635,692			0 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140213 Component CCN: 14S213	Period: From 10/01/2013 To 09/30/2014	Worksheet D Part IV Date/Time Prepared: 2/25/2015 8:07 am
Title XIX		Subprovider - IPF	PPS

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		11.00	12.00	13.00	
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
54.01	05401 ULTRASOUND	0	0	0	54.01
57.00	05700 CT SCAN	0	0	0	57.00
58.00	05800 MRI	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	65.00
65.01	06501 SLEEP LAB	0	0	0	65.01
66.00	06600 PHYSICAL THERAPY	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800 RURAL HEALTH CLINIC	0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00	09000 CLINIC	0	0	0	90.00
90.01	09001 HOMER GLEN LAB	0	0	0	90.01
90.02	09002 HOMER GLEN FEC	0	0	0	90.02
90.03	09003 WOMEN'S HEALTH	0	0	0	90.03
91.00	09100 EMERGENCY	0	0	0	91.00
91.01	09101 OP MENTAL HEALTH	0	0	0	91.01
91.02	09102 DIABETES CENTER	0	0	0	91.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0	94.00
200.00	Total (lines 50-199)	0	0	0	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS			Provider CCN: 140213 Component CCN: 14T213		Period: From 10/01/2013 To 09/30/2014		Worksheet D Part II Date/Time Prepared: 2/25/2015 8:07 am	
			Title XIX		Subprovider - IRF		PPS	
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 + col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	6,663,535	159,308,157	0.041828	0	0	50.00
51.00	05100	RECOVERY ROOM	401,131	23,153,089	0.017325	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	610,420	8,575,760	0.071180	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,517,918	144,341,469	0.031300	0	0	54.00
54.01	05401	ULTRASOUND	469,777	24,246,223	0.019375	0	0	54.01
57.00	05700	CT SCAN	736,883	87,953,743	0.008378	0	0	57.00
58.00	05800	MRI	575,739	28,438,108	0.020245	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	804,278	151,405,077	0.005312	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	123,038	8,287,596	0.014846	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	316,803	21,104,785	0.015011	0	0	65.00
65.01	06501	SLEEP LAB	52,641	2,873,576	0.018319	0	0	65.01
66.00	06600	PHYSICAL THERAPY	239,949	11,214,519	0.021396	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	127,727	12,441,524	0.010266	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	261,333	17,795,049	0.014686	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	97,883	2,456,683	0.039844	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,486,375	33,091,377	0.044917	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	930,792	34,742,600	0.026791	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,989,173	64,880,336	0.030659	0	0	73.00
74.00	07400	RENAL DIALYSIS	258,355	3,522,200	0.073350	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	63,621	854,492	0.074455	0	0	90.00
90.01	09001	HOMER GLEN LAB	65,631	5,007,707	0.013106	0	0	90.01
90.02	09002	HOMER GLEN FEC	134,747	8,865,598	0.015199	0	0	90.02
90.03	09003	WOMEN'S HEALTH	380,836	5,547,576	0.068649	0	0	90.03
91.00	09100	EMERGENCY	2,977,674	77,968,031	0.038191	0	0	91.00
91.01	09101	OP MENTAL HEALTH	221,667	1,828,506	0.121228	0	0	91.01
91.02	09102	DIABETES CENTER	19,917	415,900	0.047889	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	7,316,011	0.000000	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0.000000	0	0	94.00
200.00		Total (lines 50-199)	24,527,843	947,635,692		0	0	200.00



APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140213 Component CCN: 14T213	Period: From 10/01/2013 To 09/30/2014	Worksheet D Part IV Date/Time Prepared: 2/25/2015 8:07 am
	Title XIX	Subprovider - IRF	PPS

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	44,409	0	44,409	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	36,821	0	36,821	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401 ULTRASOUND	0	0	0	0	0	54.01
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MRI	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0	0	34,831	0	34,831	65.00
65.01	06501 SLEEP LAB	0	0	0	0	0	65.01
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	31,845	0	31,845	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000 CLINIC	0	0	0	0	0	90.00
90.01	09001 HOMER GLEN LAB	0	0	0	0	0	90.01
90.02	09002 HOMER GLEN FEC	0	0	0	0	0	90.02
90.03	09003 WOMEN'S HEALTH	0	0	0	0	0	90.03
91.00	09100 EMERGENCY	0	0	735,926	0	735,926	91.00
91.01	09101 OP MENTAL HEALTH	0	0	0	0	0	91.01
91.02	09102 DIABETES CENTER	0	0	0	0	0	91.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
200.00	Total (lines 50-199)	0	0	883,832	0	883,832	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140213 Component CCN: 14T213	Period: From 10/01/2013 To 09/30/2014	Worksheet D Part IV Date/Time Prepared: 2/25/2015 8:07 am
Title XIX		Subprovider - IRF	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	44,409	159,308,157	0.000279	0.000279		0 50.00
51.00 05100 RECOVERY ROOM	0	23,153,089	0.000000	0.000000		0 51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	36,821	8,575,760	0.004294	0.004294		0 52.00
53.00 05300 ANESTHESIOLOGY	0	0	0.000000	0.000000		0 53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	144,341,469	0.000000	0.000000		0 54.00
54.01 05401 ULTRASOUND	0	24,246,223	0.000000	0.000000		0 54.01
57.00 05700 CT SCAN	0	87,953,743	0.000000	0.000000		0 57.00
58.00 05800 MRI	0	28,438,108	0.000000	0.000000		0 58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0.000000	0.000000		0 59.00
60.00 06000 LABORATORY	0	151,405,077	0.000000	0.000000		0 60.00
60.01 06001 BLOOD LABORATORY	0	0	0.000000	0.000000		0 60.01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	8,287,596	0.000000	0.000000		0 63.00
65.00 06500 RESPIRATORY THERAPY	34,831	21,104,785	0.001650	0.001650		0 65.00
65.01 06501 SLEEP LAB	0	2,873,576	0.000000	0.000000		0 65.01
66.00 06600 PHYSICAL THERAPY	0	11,214,519	0.000000	0.000000		0 66.00
67.00 06700 OCCUPATIONAL THERAPY	0	12,441,524	0.000000	0.000000		0 67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0.000000	0.000000		0 68.00
69.00 06900 ELECTROCARDIOLOGY	31,845	17,795,049	0.001790	0.001790		0 69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	2,456,683	0.000000	0.000000		0 70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	33,091,377	0.000000	0.000000		0 71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	34,742,600	0.000000	0.000000		0 72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	64,880,336	0.000000	0.000000		0 73.00
74.00 07400 RENAL DIALYSIS	0	3,522,200	0.000000	0.000000		0 74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800 RURAL HEALTH CLINIC	0	0	0.000000	0.000000		0 88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000		0 89.00
90.00 09000 CLINIC	0	854,492	0.000000	0.000000		0 90.00
90.01 09001 HOMER GLEN LAB	0	5,007,707	0.000000	0.000000		0 90.01
90.02 09002 HOMER GLEN FEC	0	8,865,598	0.000000	0.000000		0 90.02
90.03 09003 WOMEN'S HEALTH	0	5,547,576	0.000000	0.000000		0 90.03
91.00 09100 EMERGENCY	735,926	77,968,031	0.009439	0.009439		0 91.00
91.01 09101 OP MENTAL HEALTH	0	1,828,506	0.000000	0.000000		0 91.01
91.02 09102 DIABETES CENTER	0	415,900	0.000000	0.000000		0 91.02
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	7,316,011	0.000000	0.000000		0 92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0.000000	0.000000		0 94.00
200.00 Total (lines 50-199)	883,832	947,635,692				0 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140213 Component CCN: 14T213	Period: From 10/01/2013 To 09/30/2014	Worksheet D Part IV Date/Time Prepared: 2/25/2015 8:07 am
Title XIX		Subprovider - IRF	PPS

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		11.00	12.00	13.00	
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000 OPERATING ROOM	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
54.01	05401 ULTRASOUND	0	0	0	54.01
57.00	05700 CT SCAN	0	0	0	57.00
58.00	05800 MRI	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	65.00
65.01	06501 SLEEP LAB	0	0	0	65.01
66.00	06600 PHYSICAL THERAPY	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800 RURAL HEALTH CLINIC	0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00	09000 CLINIC	0	0	0	90.00
90.01	09001 HOMER GLEN LAB	0	0	0	90.01
90.02	09002 HOMER GLEN FEC	0	0	0	90.02
90.03	09003 WOMEN'S HEALTH	0	0	0	90.03
91.00	09100 EMERGENCY	0	0	0	91.00
91.01	09101 OP MENTAL HEALTH	0	0	0	91.01
91.02	09102 DIABETES CENTER	0	0	0	91.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0	94.00
200.00	Total (lines 50-199)	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140213	Period: From 10/01/2013 To 09/30/2014	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 2/25/2015 8:07 am
Cost Center Description				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)		61,775	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		61,775	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		55,274	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)		26,966	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)		62,577,846	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)		62,577,846	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)		62,577,846	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)		1,013.00	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		27,316,558	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)		27,316,558	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140213		Period: From 10/01/2013 To 09/30/2014		Worksheet D-1 Date/Time Prepared: 2/25/2015 8:07 am	
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)	
NURSERY (title V & XIX only)		1.00	2.00	3.00	4.00	5.00	
42.00	Intensive Care Type Inpatient Hospital Units	0	0	0.00	0	0	42.00
43.00	INTENSIVE CARE UNIT	13,392,594	5,843	2,292.07	2,925	6,704,305	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)					41,235,146	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					75,256,009	49.00
<b>PASS THROUGH COST ADJUSTMENTS</b>							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					5,958,871	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					4,795,421	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					10,754,292	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					64,501,717	53.00
<b>TARGET AMOUNT AND LIMIT COMPUTATION</b>							
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
<b>PROGRAM INPATIENT ROUTINE SWING BED COST</b>							
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
<b>PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY</b>							
70.00	Skilled nursing facility/other nursing facility/ICF/MR 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
<b>PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST</b>							
87.00	Total observation bed days (see instructions)					6,501	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,013.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					6,585,513	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140213		Period: From 10/01/2013 To 09/30/2014		Worksheet D-1 Date/Time Prepared: 2/25/2015 8:07 am	
Cost Center Description		Cost	Routine Cost (from line 27)	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	11,180,118	62,577,846	0.178659	6,585,513	1,176,561	90.00
91.00	Nursing School cost	0	62,577,846	0.000000	6,585,513	0	91.00
92.00	Allied health cost	0	62,577,846	0.000000	6,585,513	0	92.00
93.00	All other Medical Education	0	62,577,846	0.000000	6,585,513	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140213	Period: From 10/01/2013 To 09/30/2014	Worksheet D-1
		Component CCN: 14S213		Date/Time Prepared: 2/25/2015 8:07 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)		4,575	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		4,575	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)		4,575	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)		1,259	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)		4,886,590	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		4,886,590	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)		4,886,590	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)		1,068.11	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,344,750	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,344,750	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140213		Period: From 10/01/2013 To 09/30/2014		Worksheet D-1	
		Component CCN: 14S213				Date/Time Prepared: 2/25/2015 8:07 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	0	42.00
<b>Intensive Care Type Inpatient Hospital Units</b>							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	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
<b>Cost Center Description</b>							
					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					164,164		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,508,914		49.00
<b>PASS THROUGH COST ADJUSTMENTS</b>							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					265,322		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					21,351		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					286,673		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					1,222,241		53.00
<b>TARGET AMOUNT AND LIMIT COMPUTATION</b>							
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
<b>PROGRAM INPATIENT ROUTINE SWING BED COST</b>							
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
<b>PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY</b>							
70.00 Skilled nursing facility/other nursing facility/ICF/MR 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
<b>PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST</b>							
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: 140213 Component CCN: 14S213		Period: From 10/01/2013 To 09/30/2014		Worksheet D-1 Date/Time Prepared: 2/25/2015 8:07 am	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description	Cost	Routine Cost (from line 27)	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	943,248	4,886,590	0.193028	0	0	90.00
91.00	Nursing School cost	0	4,886,590	0.000000	0	0	91.00
92.00	Allied health cost	20,898	4,886,590	0.004277	0	0	92.00
93.00	All other Medical Education	0	4,886,590	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140213	Period: From 10/01/2013 To 09/30/2014	Worksheet D-1
		Component CCN: 14T213		Date/Time Prepared: 2/25/2015 8:07 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)		7,472	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		7,472	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)		7,472	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)		4,908	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)		9,550,585	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)		9,550,585	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)		9,550,585	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)		1,278.18	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		6,273,307	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)		6,273,307	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140213		Period: From 10/01/2013 To 09/30/2014		Worksheet D-1	
		Component CCN: 14T213				Date/Time Prepared: 2/25/2015 8:07 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
<b>Intensive Care Type Inpatient Hospital Units</b>							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0		43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					1,988,495		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					8,261,802		49.00
<b>PASS THROUGH COST ADJUSTMENTS</b>							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					1,160,840		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					151,903		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					1,312,743		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					6,949,059		53.00
<b>TARGET AMOUNT AND LIMIT COMPUTATION</b>							
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
<b>PROGRAM INPATIENT ROUTINE SWING BED COST</b>							
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
<b>PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY</b>							
70.00 Skilled nursing facility/other nursing facility/ICF/MR 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
<b>PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST</b>							
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: 140213 Component CCN: 14T213		Period: From 10/01/2013 To 09/30/2014		Worksheet D-1 Date/Time Prepared: 2/25/2015 8:07 am	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description	Cost	Routine Cost (from line 27)	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	1,767,275	9,550,585	0.185044	0	0	90.00
91.00	Nursing School cost	0	9,550,585	0.000000	0	0	91.00
92.00	Allied health cost	0	9,550,585	0.000000	0	0	92.00
93.00	All other Medical Education	0	9,550,585	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140213	Period: From 10/01/2013 To 09/30/2014	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 2/25/2015 8:07 am
Cost Center Description				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)		61,775	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		61,775	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		55,274	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)		8,416	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		6,375	15.00
16.00	Nursery days (title V or XIX only)		991	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)		62,577,846	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)		62,577,846	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)		62,577,846	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)		1,013.00	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		8,525,408	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)		8,525,408	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 140213	Period: From 10/01/2013 To 09/30/2014	Worksheet D-1 Date/Time Prepared: 2/25/2015 8:07 am		
Cost Center Description			Title XIX	Hospital	PPS		
	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)	9,044,041	6,375	1,418.67	991	1,405,902	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	13,392,594	5,843	2,292.07	908	2,081,200	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
Cost Center Description							
						1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					12,012,510	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)					2,346,279	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)					2,346,279	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					9,666,231	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/MR ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/MR 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)					6,501	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,013.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					6,585,513	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140213		Period: From 10/01/2013 To 09/30/2014		Worksheet D-1 Date/Time Prepared: 2/25/2015 8:07 am	
Cost Center Description		Cost	Routine Cost (from line 27)	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	11,180,118	62,577,846	0.178659	6,585,513	1,176,561	90.00
91.00	Nursing School cost	0	62,577,846	0.000000	6,585,513	0	91.00
92.00	Allied health cost	0	62,577,846	0.000000	6,585,513	0	92.00
93.00	All other Medical Education	0	62,577,846	0.000000	6,585,513	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140213	Period: From 10/01/2013 To 09/30/2014	Worksheet D-1
		Component CCN: 14S213		Date/Time Prepared: 2/25/2015 8:07 am
		Title XIX	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)		4,575	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		4,575	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)		4,575	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)		951	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		6,375	15.00
16.00	Nursery days (title V or XIX only)		991	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)		4,886,590	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		4,886,590	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)		4,886,590	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)		1,068.11	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,015,773	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,015,773	41.00



COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140213		Period: From 10/01/2013 To 09/30/2014		Worksheet D-1	
		Component CCN: 14S213				Date/Time Prepared: 2/25/2015 8:07 am	
		Title XIX		Subprovider - IPF		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0		42.00
<b>Intensive Care Type Inpatient Hospital Units</b>							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0		43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,015,773		49.00
<b>PASS THROUGH COST ADJUSTMENTS</b>							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					200,414		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					200,414		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					815,359		53.00
<b>TARGET AMOUNT AND LIMIT COMPUTATION</b>							
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
<b>PROGRAM INPATIENT ROUTINE SWING BED COST</b>							
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
<b>PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY</b>							
70.00 Skilled nursing facility/other nursing facility/ICF/MR 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
<b>PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST</b>							
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: 140213 Component CCN: 14S213		Period: From 10/01/2013 To 09/30/2014		Worksheet D-1 Date/Time Prepared: 2/25/2015 8:07 am	
		Title XIX		Subprovider - IPF		PPS	
Cost Center Description	Cost	Routine Cost (from line 27)	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	943,248	4,886,590	0.193028	0	0	90.00
91.00	Nursing School cost	0	4,886,590	0.000000	0	0	91.00
92.00	Allied health cost	20,898	4,886,590	0.004277	0	0	92.00
93.00	All other Medical Education	0	4,886,590	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140213	Period: From 10/01/2013 To 09/30/2014	Worksheet D-1
		Component CCN: 14T213		Date/Time Prepared: 2/25/2015 8:07 am
		Title XIX	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)		7,472	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		7,472	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)		7,472	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)		196	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		6,375	15.00
16.00	Nursery days (title V or XIX only)		991	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)		9,550,585	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)		9,550,585	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)		9,550,585	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)		1,278.18	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		250,523	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)		250,523	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140213		Period: From 10/01/2013 To 09/30/2014		Worksheet D-1	
		Component CCN: 14T213				Date/Time Prepared: 2/25/2015 8:07 am	
		Title XIX		Subprovider - IRF		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	0	42.00
<b>Intensive Care Type Inpatient Hospital Units</b>							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	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
<b>Cost Center Description</b>							
					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0	0	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					250,523	49.00	49.00
<b>PASS THROUGH COST ADJUSTMENTS</b>							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					46,358	50.00	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	51.00	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					46,358	52.00	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					204,165	53.00	53.00
<b>TARGET AMOUNT AND LIMIT COMPUTATION</b>							
54.00 Program discharges					0	54.00	54.00
55.00 Target amount per discharge					0.00	55.00	55.00
56.00 Target amount (line 54 x line 55)					0	56.00	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00	57.00
58.00 Bonus payment (see instructions)					0	58.00	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	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	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	61.00
62.00 Relief payment (see instructions)					0	62.00	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00	63.00
<b>PROGRAM INPATIENT ROUTINE SWING BED COST</b>							
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	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	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	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	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	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00	69.00
<b>PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY</b>							
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)						70.00	70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00	71.00
72.00 Program routine service cost (line 9 x line 71)						72.00	72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00	73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)						74.00	74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00	75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)						76.00	76.00
77.00 Program capital-related costs (line 9 x line 76)						77.00	77.00
78.00 Inpatient routine service cost (line 74 minus line 77)						78.00	78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)						79.00	79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00	80.00
81.00 Inpatient routine service cost per diem limitation						81.00	81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)						82.00	82.00
83.00 Reasonable inpatient routine service costs (see instructions)						83.00	83.00
84.00 Program inpatient ancillary services (see instructions)						84.00	84.00
85.00 Utilization review - physician compensation (see instructions)						85.00	85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)						86.00	86.00
<b>PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST</b>							
87.00 Total observation bed days (see instructions)					0	87.00	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	88.00	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0	89.00	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140213 Component CCN: 14T213		Period: From 10/01/2013 To 09/30/2014		Worksheet D-1 Date/Time Prepared: 2/25/2015 8:07 am	
		Title XIX		Subprovider - IRF		PPS	
Cost Center Description	Cost	Routine Cost (from line 27)	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	1,767,275	9,550,585	0.185044	0	0	90.00
91.00	Nursing School cost	0	9,550,585	0.000000	0	0	91.00
92.00	Allied health cost	0	9,550,585	0.000000	0	0	92.00
93.00	All other Medical Education	0	9,550,585	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140213	Period: From 10/01/2013 To 09/30/2014	Worksheet D-3 Date/Time Prepared: 2/25/2015 8:07 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	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		30,113,409	30.00
31.00	03100	INTENSIVE CARE UNIT		7,773,611	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY		0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.204956	20,149,875	50.00
51.00	05100	RECOVERY ROOM	0.111982	3,479,328	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.706686	3,163	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.182557	19,047,143	54.00
54.01	05401	ULTRASOUND	0.105967	3,527,847	54.01
57.00	05700	CT SCAN	0.038435	14,637,219	57.00
58.00	05800	MRI	0.080082	4,321,217	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.081055	25,750,729	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.280339	7,153,617	63.00
65.00	06500	RESPIRATORY THERAPY	0.146266	10,630,311	65.00
65.01	06501	SLEEP LAB	0.177673	0	65.01
66.00	06600	PHYSICAL THERAPY	0.344137	3,103,019	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.207264	1,572,774	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.121645	6,218,092	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.252884	372,423	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.529844	14,744,809	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.573607	9,835,062	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.324595	19,919,825	73.00
74.00	07400	RENAL DIALYSIS	0.355578	2,199,374	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	89.00
90.00	09000	CLINIC	1.450415	24,668	90.00
90.01	09001	HOMER GLEN LAB	0.232664	381,279	90.01
90.02	09002	HOMER GLEN FEC	0.219629	125,133	90.02
90.03	09003	WOMEN'S HEALTH	0.388295	1,829	90.03
91.00	09100	EMERGENCY	0.215798	12,359,294	91.00
91.01	09101	OP MENTAL HEALTH	0.559178	0	91.01
91.02	09102	DIABETES CENTER	0.978117	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.900151	600,151	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
94.00	09400	HOME PROGRAM DIALYSIS	0.000000	0	94.00
200.00		Total (sum of lines 50-94 and 96-98)		180,158,181	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)		180,158,181	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140213	Period: From 10/01/2013 To 09/30/2014	Worksheet D-3	
		Component CCN: 14S213		Date/Time Prepared: 2/25/2015 8:07 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		1,372,434	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY		0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.204956	19,022	50.00
51.00	05100	RECOVERY ROOM	0.111982	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.706686	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.182557	11,596	54.00
54.01	05401	ULTRASOUND	0.105967	13,492	54.01
57.00	05700	CT SCAN	0.038435	15,482	57.00
58.00	05800	MRI	0.080082	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.081055	232,382	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.280339	52,244	63.00
65.00	06500	RESPIRATORY THERAPY	0.146266	30,471	65.00
65.01	06501	SLEEP LAB	0.177673	0	65.01
66.00	06600	PHYSICAL THERAPY	0.344137	4,401	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.207264	3,191	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.121645	13,330	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.252884	1,190	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.529844	3,829	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.573607	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.324595	184,618	73.00
74.00	07400	RENAL DIALYSIS	0.355578	7,916	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	89.00
90.00	09000	CLINIC	1.450415	837	90.00
90.01	09001	HOMER GLEN LAB	0.232664	3,483	90.01
90.02	09002	HOMER GLEN FEC	0.219629	2,191	90.02
90.03	09003	WOMEN'S HEALTH	0.388295	0	90.03
91.00	09100	EMERGENCY	0.215798	216,914	91.00
91.01	09101	OP MENTAL HEALTH	0.559178	0	91.01
91.02	09102	DIABETES CENTER	0.978117	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.900151	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
94.00	09400	HOME PROGRAM DIALYSIS	0.000000	0	94.00
200.00		Total (sum of lines 50-94 and 96-98)		816,589	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)		816,589	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140213	Period: From 10/01/2013 To 09/30/2014	Worksheet D-3	
		Component CCN: 14T213		Date/Time Prepared: 2/25/2015 8:07 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		4,948,582	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY			43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.204956	159,564	50.00
51.00	05100	RECOVERY ROOM	0.111982	595	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.706686	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.182557	177,732	54.00
54.01	05401	ULTRASOUND	0.105967	92,932	54.01
57.00	05700	CT SCAN	0.038435	183,377	57.00
58.00	05800	MRI	0.080082	47,842	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.081055	756,171	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.280339	221,345	63.00
65.00	06500	RESPIRATORY THERAPY	0.146266	530,622	65.00
65.01	06501	SLEEP LAB	0.177673	0	65.01
66.00	06600	PHYSICAL THERAPY	0.344137	2,241,663	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.207264	2,124,672	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.121645	32,874	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.252884	3,034	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.529844	204,707	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.573607	4,508	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.324595	1,018,905	73.00
74.00	07400	RENAL DIALYSIS	0.355578	107,664	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
90.00	09000	CLINIC	1.450415	1,530	90.00
90.01	09001	HOMER GLEN LAB	0.232664	11,705	90.01
90.02	09002	HOMER GLEN FEC	0.219629	0	90.02
90.03	09003	WOMEN'S HEALTH	0.388295	0	90.03
91.00	09100	EMERGENCY	0.215798	82	91.00
91.01	09101	OP MENTAL HEALTH	0.559178	0	91.01
91.02	09102	DIABETES CENTER	0.978117	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.900151	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
94.00	09400	HOME PROGRAM DIALYSIS	0.000000	0	94.00
200.00		Total (sum of lines 50-94 and 96-98)		7,921,524	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)		7,921,524	202.00



CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140213	Period: From 10/01/2013 To 09/30/2014	Worksheet E Part A Date/Time Prepared: 2/25/2015 8:07 am	
		Title XVIII	Hospital		PPS
		0	before 1/1	on/after 1/1	2.00
<b>PART A - INPATIENT HOSPITAL SERVICES UNDER PPS</b>					
1.00	DRG Amounts Other than Outlier Payments		51,687,016		1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1, 2013 (see instructions)		0		1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1, 2013 (see instructions)		0		1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI (see instructions)		0		1.03
2.00	Outlier payments for discharges. (see instructions)		820,102		2.00
2.01	Outlier reconciliation amount		0		2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0		2.02
3.00	Managed Care Simulated Payments		4,347,747		3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		233.19		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)		0.00		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.		0.00		7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 Federal Register, page 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)		0.00		9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00		10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00		11.00
12.00	Current year allowable FTE (see instructions)		0.00		12.00
13.00	Total allowable FTE count for the prior year.		0.00		13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00		14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00		15.00
16.00	Adjustment for residents in initial years of the program		0.00		16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00		17.00
18.00	Adjusted rolling average FTE count		0.00		18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000		19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000		20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000		21.00
22.00	IME payment adjustment (see instructions)		0		22.00
<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)		0.00		24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00		25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000		26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000		27.00
28.00	IME add-on adjustment amount (see instructions)		0		28.00
29.00	Total IME payment ( sum of lines 22 and 28)		0		29.00
<b>Disproportionate Share Adjustment</b>					
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		3.13		30.00
31.00	Percentage of Medicaid patient days (see instructions)		15.54		31.00
32.00	Sum of lines 30 and 31		18.67		32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140213	Period: From 10/01/2013 To 09/30/2014	Worksheet E Part A Date/Time Prepared: 2/25/2015 8:07 am	
		Title XVIII	Hospital		PPS
		0	before 1/1	on/after 1/1	2.00
33.00	Allowable disproportionate share percentage (see instructions)		4.89	1.01	33.00
34.00	Disproportionate share adjustment (see instructions)		631,874		34.00
		0	Prior to October 1	1.01	On/After October 1
		0	1.00	1.01	2.00
<b>Uncompensated Care Adjustment</b>					
35.00	Total uncompensated care amount (see instructions)		0		9,046,380,143 35.00
35.01	Factor 3 (see instructions)		0.000000000		0.000290944 35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		0		2,631,986 35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		0		2,631,986 35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		2,631,986		36.00
<b>Additional payment for high percentage of ESRD beneficiary discharges</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
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)		55,770,978		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0		48.00
49.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)		55,770,978		49.00
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)		4,506,202		50.00
51.00	Exception payment for inpatient program capital (Worksheet L, Part III, see instructions)		0		51.00
52.00	Direct graduate medical education payment (from Worksheet E-4, line 49 see instructions).		0		52.00
53.00	Nursing and Allied Health Managed Care payment		5,554		53.00
54.00	Special add-on payments for new technologies		1,705		54.00
55.00	Net organ acquisition cost (Worksheet D-4 Part 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, Part III, column 9, lines 30 through 35).		35,363		57.00
58.00	Ancillary service other pass through costs from Worksheet D, Part IV, col. 11 line 200)		150,965		58.00
59.00	Total (sum of amounts on lines 49 through 58)		60,470,767		59.00
60.00	Primary payer payments		11,190		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		60,459,577		61.00
62.00	Deductibles billed to program beneficiaries		5,807,936		62.00
63.00	Coinurance billed to program beneficiaries		163,760		63.00
64.00	Allowable bad debts (see instructions)		909,815		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		591,380		65.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140213	Period: From 10/01/2013 To 09/30/2014	Worksheet E Part A Date/Time Prepared: 2/25/2015 8:07 am
		Title XVIII	Hospital	PPS

		Prior to October 1		On/After October 1	
		1.00	1.01	2.00	
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		665,298		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		55,079,261		67.00
68.00	Credits received from manufacturers for replaced devices applicable to MS-DRG (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
70.92	Bundled Model 1 discount amount		0		70.92
70.93	HVBP incentive payment (see instructions)		141,392		70.93
70.94	Hospital readmissions reduction adjustment (see instructions)		-501,380		70.94
70.95	Recovery of accelerated depreciation		0		70.95
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
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		54,719,273		71.00
71.01	Sequestration adjustment (see instructions)		1,094,385		71.01
72.00	Interim payments		53,900,869		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		-275,981		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		1,131,294		75.00
<b>TO BE COMPLETED BY CONTRACTOR</b>					
90.00	Operating outlier amount from Worksheet E, Part A line 2 (see instructions)		0		90.00
91.00	Capital outlier from Worksheet L, Part 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

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 140213

Period:  
From 10/01/2013  
To 09/30/2014

Worksheet E  
Part A Exhibit 4  
Date/Time Prepared:  
2/25/2015 8:07 am

		Title XVIII			Hospital		PPS	
	W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)		
	0	1.00	2.00	3.00	4.00	5.00		
1.00	DRG amounts other than outlier payments	1.00	51,687,016	0	0	51,687,016	51,687,016	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1, 2013	1.01	0	0	0	0	0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1, 2013	1.02	0	0	0	0	0	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI	1.03	0	0	0	0	0	1.03
2.00	Outlier payments for discharges (see instructions)	2.00	820,102	0	0	820,102	820,102	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	4,347,747	0	0	0	0	4.00
<b>Indirect Medical Education Adjustment</b>								
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
<b>Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA</b>								
7.00	Amount from Worksheet E Part A, line 27 (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
<b>Disproportionate Share Adjustment</b>								
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0489	0.0489	0.0489	0.0489		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	631,874	0	0	631,874	631,874	11.00
11.01	Uncompensated care payments	36.00	2,631,986	0	0	0	0	11.01
<b>Additional payment for high percentage of ESRD beneficiary discharges</b>								
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	55,770,978	0	0	55,770,978	55,770,978	13.00
14.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)	49.00	55,770,978	0	0	55,770,978	55,770,978	15.00
16.00	Payment for inpatient program capital (from Worksheet L, Parts I, as applicable)	50.00	4,506,202	0	0	4,506,202	4,506,202	16.00
17.00	Special add-on payments for new technologies	54.00	1,705	0	0	1,705	1,705	17.00
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00
19.00	SUBTOTAL			0	0	60,278,885	60,278,885	19.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 140213

Period:  
From 10/01/2013  
To 09/30/2014

Worksheet E  
Part A Exhibit 4  
Date/Time Prepared:  
2/25/2015 8:07 am

		Title XVIII		Hospital		PPS		
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	4,130,438	0	0	4,130,438	4,130,438	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	216,742	0	0	216,742	216,742	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (line 20 times line 22)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0385	0.0385	0.0385	0.0385		24.00
25.00	Disproportionate share adjustment (line 20 times line 24)	11.00	159,022	0	0	159,022	159,022	25.00
26.00	Total prospective capital payments (sum of lines 20-21, 23 and 25)	12.00	4,506,202	0	0	4,506,202	4,506,202	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to W/S E Part A line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to W/S E Part A line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to W/S E Part A.		N					100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140213	Period: From 10/01/2013 To 09/30/2014	Worksheet E Part B Date/Time Prepared: 2/25/2015 8:07 am
		Title XVII	Hospital	PPS
		1.00		
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)		47,590	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		23,980,573	2.00
3.00	PPS payments		20,851,279	3.00
4.00	Outlier payment (see instructions)		79,283	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 Worksheet D, Part IV, column 13, line 200		87,347	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		47,590	11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges		103,270	12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		103,270	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 charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		103,270	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		55,680	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)		47,590	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)		21,017,909	24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance (for CAH, see instructions)		11,785	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		4,548,352	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)		16,505,362	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		16,505,362	30.00
31.00	Primary payer payments		1,528	31.00
32.00	Subtotal (line 30 minus line 31)		16,503,834	32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Worksheet I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		547,309	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		355,751	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		416,974	36.00
37.00	Subtotal (see instructions)		16,859,585	37.00
38.00	MSP-LCC reconciliation amount from PS&R		-136	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
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)		16,859,721	40.00
40.01	Sequestration adjustment (see instructions)		337,194	40.01
41.00	Interim payments		16,790,531	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-268,004	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		371,106	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: 140213	Period: From 10/01/2013 To 09/30/2014	Worksheet E Part B Date/Time Prepared: 2/25/2015 8:07 am
		Component CCN: 14T213	Title XVII I	Subprovider - IRF
		PPS		
		1.00		
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)		73	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		13,277	2.00
3.00	PPS payments		13,800	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 Worksheet D, Part IV, column 13, line 200		202	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		73	11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges		224	12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		224	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 charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		224	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		151	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)		73	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)		14,002	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)		3,231	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)		10,844	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		10,844	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		10,844	32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Worksheet 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)		10,844	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.98	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)		10,844	40.00
40.01	Sequestration adjustment (see instructions)		217	40.01
41.00	Interim payments		10,445	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		182	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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140213

Period:  
From 10/01/2013  
To 09/30/2014

Worksheet E-1  
Part I  
Date/Time Prepared:  
2/25/2015 8:07 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		52,988,906		16,076,084	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		832,251		549,932	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	05/20/2014	79,712	05/20/2014	164,515	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)		79,712		164,515	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)		53,900,869		16,790,531	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00	
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00	
6.01	SETTLEMENT TO PROVIDER		0		0	6.01	
6.02	SETTLEMENT TO PROGRAM		275,981		268,004	6.02	
7.00	Total Medicare program liability (see instructions)		53,624,888		16,522,527	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: 140213  
Component CCN: 14S213

Period:  
From 10/01/2013  
To 09/30/2014

Worksheet E-1  
Part I  
Date/Time Prepared:  
2/25/2015 8:07 am  
PPS

Title XVIII

Subprovider -  
IPF

		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		922,158		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		922,158		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		78,737		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,000,895		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140213  
Component CCN: 14T213

Period:  
From 10/01/2013  
To 09/30/2014

Worksheet E-1  
Part I  
Date/Time Prepared:  
2/25/2015 8:07 am  
PPS

Title XVIII

Subprovider -  
IRF

		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		7,042,114		10,445	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	05/20/2014	8,656		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)		8,656		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)		7,050,770		10,445	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		15,642		182	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		7,066,412		10,627	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: 140213	Period: From 10/01/2013 To 09/30/2014	Worksheet E-1 Part II Date/Time Prepared: 2/25/2015 8:07 am
		Title XVIII	Hospital	PPS
				1.00
<b>TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD 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, Part I column 15 line 14			20,495 1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12			29,891 2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6, line 2			2,570 3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12			61,117 4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200			1,051,398,794 5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20			27,115,000 6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168			0 7.00
8.00	Calculation of the HIT incentive payment (see instructions)			2,399,916 8.00
9.00	Sequestration adjustment amount (see instructions)			47,998 9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)			2,351,918 10.00
<b>INPATIENT HOSPITAL SERVICES UNDER PPS &amp; CAH</b>				
30.00	Initial/interim HIT payment adjustment (see instructions)			2,323,257 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)			28,661 32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140213	Period: From 10/01/2013 To 09/30/2014	Worksheet E-3 Part II Date/Time Prepared: 2/25/2015 8:07 am
		Component CCN: 14S213	Title XVII	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)		1,071,365	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 §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 inst.)		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 inst.)		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)		12.534247	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)		1,071,365	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)		0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)			14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)		0	15.00
16.00	Subtotal (see instructions)		1,071,365	16.00
17.00	Primary payer payments		0	17.00
18.00	Subtotal (line 16 less line 17).		1,071,365	18.00
19.00	Deductibles		122,980	19.00
20.00	Subtotal (line 18 minus line 19)		948,385	20.00
21.00	Coinsurance		7,400	21.00
22.00	Subtotal (line 20 minus line 21)		940,985	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		111,471	23.00
24.00	Adjusted reimbursable bad debts (see instructions)		72,456	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		94,281	25.00
26.00	Subtotal (sum of lines 22 and 24)		1,013,441	26.00
27.00	Direct graduate medical education payments (from Worksheet E-4, line 49)		0	27.00
28.00	Other pass through costs (see instructions)		7,880	28.00
29.00	Outlier payments reconciliation		0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	30.00
30.99	Recovery of Accelerated Depreciation		0	30.99
31.00	Total amount payable to the provider (see instructions)		1,021,321	31.00
31.01	Sequestration adjustment (see instructions)		20,426	31.01
32.00	Interim payments		922,158	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		78,737	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		9,192	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: 140213 Component CCN: 14T213	Period: From 10/01/2013 To 09/30/2014	Worksheet E-3 Part III Date/Time Prepared: 2/25/2015 8:07 am
		Title XVIIII	Subprovider - IRF	PPS
				1.00
<b>PART III - MEDICARE PART A SERVICES - IRF PPS</b>				
1.00	Net Federal PPS Payment (see instructions)			6,672,194 1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0067 2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			68,724 3.00
4.00	Outlier Payments			548,152 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 §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 inst.)			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 inst.)			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)			20.471233 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)			7,289,070 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)			7,289,070 17.00
18.00	Primary payer payments			0 18.00
19.00	Subtotal (line 17 less line 18).			7,289,070 19.00
20.00	Deductibles			28,800 20.00
21.00	Subtotal (line 19 minus line 20)			7,260,270 21.00
22.00	Coinsurance			53,704 22.00
23.00	Subtotal (line 21 minus line 22)			7,206,566 23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			4,736 24.00
25.00	Adjusted reimbursable bad debts (see instructions)			3,078 25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			2,368 26.00
27.00	Subtotal (sum of lines 23 and 25)			7,209,644 27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 49)			0 28.00
29.00	Other pass through costs (see instructions)			981 29.00
30.00	Outlier payments reconciliation			0 30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 31.00
31.99	Recovery of Accelerated Depreciation			0 31.99
32.00	Total amount payable to the provider (see instructions)			7,210,625 32.00
32.01	Sequestration adjustment (see instructions)			144,213 32.01
33.00	Interim payments			7,050,770 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			15,642 35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			231 36.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
50.00	Original outlier amount from Worksheet E-3, Part III, line 4			548,152 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

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

Provider CCN: 140213

Period:  
From 10/01/2013  
To 09/30/2014

Worksheet G

Date/Time Prepared:  
2/25/2015 8:07 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	16,464,000	0	0	0	1.00
2.00	Temporary investments	2,603,000	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	47,174,000	0	0	0	4.00
5.00	Other receivable	464,000	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	3,474,000	0	0	0	8.00
9.00	Other current assets	1,559,000	0	0	0	9.00
10.00	Due from other funds	42,222,000	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	113,960,000	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	570,784,168	0	0	0	15.00
16.00	Accumulated depreciation	-136,200,168	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	434,584,000	0	0	0	30.00
<b>OTHER ASSETS</b>						
31.00	Investments	143,321,000	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	34,005,000	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	177,326,000	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	725,870,000	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	16,060,000	0	0	0	37.00
38.00	Salaries, wages, and fees payable	16,989,000	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	5,610,000	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	37,801,000	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	76,460,000	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	381,686,000	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	891,000	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	382,577,000	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	459,037,000	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	266,833,000	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	266,833,000	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	725,870,000	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 140213

Period:  
From 10/01/2013  
To 09/30/2014

Worksheet G-1

Date/Time Prepared:  
2/25/2015 8:07 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		256,446,006		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		8,933,473			2.00
3.00	Total (sum of line 1 and line 2)		265,379,479		0	3.00
4.00	TEMPORARILY RESTRICTED NET ASSETS	4,011,000		0		4.00
5.00	CONTRIBUTIONS FOR SPECIFIC PURPOSES	-8,659,479		0		5.00
6.00	PERMANENTLY RESTRICTED ASSETS	6,102,000		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		1,453,521		0	10.00
11.00	Subtotal (line 3 plus line 10)		266,833,000		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		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)		266,833,000		0	19.00
		Endowment Fund		Plant Fund		
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	TEMPORARILY RESTRICTED NET ASSETS		0			4.00
5.00	CONTRIBUTIONS FOR SPECIFIC PURPOSES		0			5.00
6.00	PERMANENTLY RESTRICTED ASSETS		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: 140213

Period:  
From 10/01/2013  
To 09/30/2014

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
2/25/2015 8:07 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	60,306,633		60,306,633	1.00
2.00	SUBPROVIDER - IPF	4,995,564		4,995,564	2.00
3.00	SUBPROVIDER - IRF	9,447,432		9,447,432	3.00
4.00	SUBPROVIDER	0		0	4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	0		0	7.00
8.00	NURSING FACILITY	0		0	8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	74,749,629		74,749,629	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	15,443,790		15,443,790	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	15,443,790		15,443,790	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	90,193,419		90,193,419	17.00
18.00	Ancillary services	395,341,851	426,102,994	821,444,845	18.00
19.00	Outpatient services	26,242,565	81,561,255	107,803,820	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		4,882,767	4,882,767	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC		0	0	24.00
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00		0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	511,777,835	512,547,016	1,024,324,851	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		319,146,939		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)		319,146,939		43.00



STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 140213

Period:  
From 10/01/2013  
To 09/30/2014

Worksheet G-3

Date/Time Prepared:  
2/25/2015 8:07 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	1,024,324,851	1.00
2.00	Less contractual allowances and discounts on patients' accounts	715,317,358	2.00
3.00	Net patient revenues (line 1 minus line 2)	309,007,493	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	319,146,939	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-10,139,446	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	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISC - OTHER REVENUE	11,164,431	24.00
24.01	NON-OPERATING INCOME	7,908,488	24.01
25.00	Total other income (sum of lines 6-24)	19,072,919	25.00
26.00	Total (line 5 plus line 25)	8,933,473	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)	8,933,473	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 140213

Period: From 10/01/2013

Worksheet H

HHA CCN: 147452

To 09/30/2014

Date/Time Prepared: 2/25/2015 8:07 am

Home Health Agency I

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	Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of col. 1 thru 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00			0		0	0	1.00
2.00			0		0	0	2.00
3.00	0	0	0	0	0	0	3.00
4.00	0	0	0	0	0	0	4.00
5.00	496,751	0	51	495	31,037	528,334	5.00
<b>HHA REIMBURSABLE SERVICES</b>							
6.00	941,724	0	59,756	0	55,396	1,056,876	6.00
7.00	0	0	0	781,217	0	781,217	7.00
8.00	0	0	0	0	0	0	8.00
9.00	0	0	0	0	0	0	9.00
10.00	5,444	0	0	0	0	5,444	10.00
11.00	46,405	0	7,430	0	0	53,835	11.00
12.00	0	0	0	0	0	0	12.00
13.00	0	0	0	0	0	0	13.00
14.00	0	0	0	0	0	0	14.00
<b>HHA NONREIMBURSABLE SERVICES</b>							
15.00	0	0	0	0	0	0	15.00
16.00	0	0	0	0	0	0	16.00
17.00	0	0	0	0	0	0	17.00
18.00	0	0	0	0	0	0	18.00
19.00	0	0	0	0	0	0	19.00
20.00	0	0	0	0	0	0	20.00
21.00	0	0	0	0	0	0	21.00
22.00	0	0	0	0	0	0	22.00
23.00	0	0	0	0	0	0	23.00
24.00	1,490,324	0	67,237	781,712	86,433	2,425,706	24.00
	Reclassifi cation	Reclassifi ed Trial Balance (col. 6 + col. 7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
	7.00	8.00	9.00	10.00			
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	0	0	0	0			1.00
2.00	0	0	0	0			2.00
3.00	0	0	0	0			3.00
4.00	0	0	0	0			4.00
5.00	35,000	563,334	0	563,334			5.00
<b>HHA REIMBURSABLE SERVICES</b>							
6.00	0	1,056,876	0	1,056,876			6.00
7.00	-19,481	761,736	0	761,736			7.00
8.00	0	0	0	0			8.00
9.00	0	0	0	0			9.00
10.00	0	5,444	0	5,444			10.00
11.00	0	53,835	0	53,835			11.00
12.00	0	0	0	0			12.00
13.00	0	0	0	0			13.00
14.00	0	0	0	0			14.00
<b>HHA NONREIMBURSABLE SERVICES</b>							
15.00	0	0	0	0			15.00
16.00	0	0	0	0			16.00
17.00	0	0	0	0			17.00
18.00	0	0	0	0			18.00
19.00	0	0	0	0			19.00
20.00	0	0	0	0			20.00
21.00	0	0	0	0			21.00
22.00	0	0	0	0			22.00
23.00	0	0	0	0			23.00
24.00	15,519	2,441,225	0	2,441,225			24.00

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

COST ALLOCATION - HHA GENERAL SERVICE COST		Provider CCN: 140213	Period: From 10/01/2013 To 09/30/2014	Worksheet H-1 Part I Date/Time Prepared: 2/25/2015 8:07 am
		HHA CCN: 147452	Home Health Agency I	PPS

	Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)		
		Bldgs & Fixtures	Movable Equipment					
		1.00	2.00					3.00
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	Capital Related - Bldg. & Fixtures	0	0			0	1.00	
2.00	Capital Related - Movable Equipment	0	0			0	2.00	
3.00	Plant Operation & Maintenance	0	0	0		0	3.00	
4.00	Transportation	0	0	0	0	0	4.00	
5.00	Administrative and General	563,334	0	0	0	563,334	5.00	
<b>HHA REIMBURSABLE SERVICES</b>								
6.00	Skilled Nursing Care	1,056,876	0	0	0	1,056,876	6.00	
7.00	Physical Therapy	761,736	0	0	0	761,736	7.00	
8.00	Occupational Therapy	0	0	0	0	0	8.00	
9.00	Speech Pathology	0	0	0	0	0	9.00	
10.00	Medical Social Services	5,444	0	0	0	5,444	10.00	
11.00	Home Health Aide	53,835	0	0	0	53,835	11.00	
12.00	Supplies (see instructions)	0	0	0	0	0	12.00	
13.00	Drugs	0	0	0	0	0	13.00	
14.00	DME	0	0	0	0	0	14.00	
<b>HHA NONREIMBURSABLE SERVICES</b>								
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00	
16.00	Respiratory Therapy	0	0	0	0	0	16.00	
17.00	Private Duty Nursing	0	0	0	0	0	17.00	
18.00	Clinic	0	0	0	0	0	18.00	
19.00	Health Promotion Activities	0	0	0	0	0	19.00	
20.00	Day Care Program	0	0	0	0	0	20.00	
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00	
22.00	Homemaker Service	0	0	0	0	0	22.00	
23.00	All Others (specify)	0	0	0	0	0	23.00	
24.00	Total (sum of lines 1-23)	2,441,225	0	0	0	2,441,225	24.00	
		Administrative & General	Total (cols. 4A + 5)					
		5.00	6.00					
<b>GENERAL SERVICE COST CENTERS</b>								
1.00	Capital Related - Bldg. & Fixtures						1.00	
2.00	Capital Related - Movable Equipment						2.00	
3.00	Plant Operation & Maintenance						3.00	
4.00	Transportation						4.00	
5.00	Administrative and General	563,334					5.00	
<b>HHA REIMBURSABLE SERVICES</b>								
6.00	Skilled Nursing Care	317,044	1,373,920				6.00	
7.00	Physical Therapy	228,507	990,243				7.00	
8.00	Occupational Therapy	0	0				8.00	
9.00	Speech Pathology	0	0				9.00	
10.00	Medical Social Services	1,633	7,077				10.00	
11.00	Home Health Aide	16,150	69,985				11.00	
12.00	Supplies (see instructions)	0	0				12.00	
13.00	Drugs	0	0				13.00	
14.00	DME	0	0				14.00	
<b>HHA NONREIMBURSABLE SERVICES</b>								
15.00	Home Dialysis Aide Services	0	0				15.00	
16.00	Respiratory Therapy	0	0				16.00	
17.00	Private Duty Nursing	0	0				17.00	
18.00	Clinic	0	0				18.00	
19.00	Health Promotion Activities	0	0				19.00	
20.00	Day Care Program	0	0				20.00	
21.00	Home Delivered Meals Program	0	0				21.00	
22.00	Homemaker Service	0	0				22.00	
23.00	All Others (specify)	0	0				23.00	
24.00	Total (sum of lines 1-23)		2,441,225				24.00	

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 140213

Period:

Worksheet H-1

HHA CCN: 147452

From 10/01/2013  
To 09/30/2014

Part II  
Date/Time Prepared:  
2/25/2015 8:07 am

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	Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
	Bl dgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)					
	1.00	2.00					
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	Capital Related - Bldg. & Fixtures	0			0		1.00
2.00	Capital Related - Movable Equipment		0		0		2.00
3.00	Plant Operation & Maintenance	0	0	0	0		3.00
4.00	Transportation (see instructions)	0	0	0	0		4.00
5.00	Administrative and General	0	0	0	0	-563,334	1,877,891
<b>HHA REIMBURSABLE SERVICES</b>							
6.00	Skilled Nursing Care	0	0	0	0	0	1,056,876
7.00	Physical Therapy	0	0	0	0	0	761,736
8.00	Occupational Therapy	0	0	0	0	0	0
9.00	Speech Pathology	0	0	0	0	0	0
10.00	Medical Social Services	0	0	0	0	0	5,444
11.00	Home Health Aide	0	0	0	0	0	53,835
12.00	Supplies (see instructions)	0	0	0	0	0	0
13.00	Drugs	0	0	0	0	0	0
14.00	DME	0	0	0	0	0	0
<b>HHA NONREIMBURSABLE SERVICES</b>							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0
16.00	Respiratory Therapy	0	0	0	0	0	0
17.00	Private Duty Nursing	0	0	0	0	0	0
18.00	Clinic	0	0	0	0	0	0
19.00	Health Promotion Activities	0	0	0	0	0	0
20.00	Day Care Program	0	0	0	0	0	0
21.00	Home Delivered Meals Program	0	0	0	0	0	0
22.00	Homemaker Service	0	0	0	0	0	0
23.00	All Others (specify)	0	0	0	0	0	0
24.00	Total (sum of lines 1-23)	0	0	0	0	-563,334	1,877,891
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		563,334
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.299982

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 140213

Period: From 10/01/2013

Worksheet H-2

HHA CCN: 147452

To 09/30/2014

Part I  
Date/Time Prepared:  
2/25/2015 8:07 am

Home Health Agency I

PPS

Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		BLDG & FIXT	MVBLE EQUIP					
		1.00	2.00	4.00				
	0				4A	5.00		
1.00 Administrative and General	0	0	1,285	512,622	513,907	141,902	1.00	
2.00 Skilled Nursing Care	1,373,920	0	0	0	1,373,920	379,371	2.00	
3.00 Physical Therapy	990,243	0	0	0	990,243	273,429	3.00	
4.00 Occupational Therapy	0	0	0	0	0	0	4.00	
5.00 Speech Pathology	0	0	0	0	0	0	5.00	
6.00 Medical Social Services	7,077	0	0	0	7,077	1,954	6.00	
7.00 Home Health Aide	69,985	0	0	0	69,985	19,324	7.00	
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00	
9.00 Drugs	0	0	0	0	0	0	9.00	
10.00 DME	0	0	0	0	0	0	10.00	
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00	
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00	
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00	
14.00 Clinic	0	0	0	0	0	0	14.00	
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00	
16.00 Day Care Program	0	0	0	0	0	0	16.00	
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00	
18.00 Homemaker Service	0	0	0	0	0	0	18.00	
19.00 All Others (specify)	0	0	0	0	0	0	19.00	
20.00 Total (sum of lines 1-19) (2)	2,441,225	0	1,285	512,622	2,955,132	815,980	20.00	
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000		21.00	
Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION		
	7.00	8.00	9.00	10.00	11.00	13.00		
1.00 Administrative and General	0	0	0	0	0	132,091	1.00	
2.00 Skilled Nursing Care	0	0	0	0	0	0	2.00	
3.00 Physical Therapy	0	0	0	0	0	0	3.00	
4.00 Occupational Therapy	0	0	0	0	0	0	4.00	
5.00 Speech Pathology	0	0	0	0	0	0	5.00	
6.00 Medical Social Services	0	0	0	0	0	0	6.00	
7.00 Home Health Aide	0	0	0	0	0	0	7.00	
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00	
9.00 Drugs	0	0	0	0	0	0	9.00	
10.00 DME	0	0	0	0	0	0	10.00	
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00	
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00	
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00	
14.00 Clinic	0	0	0	0	0	0	14.00	
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00	
16.00 Day Care Program	0	0	0	0	0	0	16.00	
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00	
18.00 Homemaker Service	0	0	0	0	0	0	18.00	
19.00 All Others (specify)	0	0	0	0	0	0	19.00	
20.00 Total (sum of lines 1-19) (2)	0	0	0	0	0	132,091	20.00	
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00	

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 140213

Period: From 10/01/2013

Worksheet H-2

HHA CCN: 147452

To 09/30/2014

Part I Date/Time Prepared: 2/25/2015 8:07 am

Home Health Agency I

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Cost Center Description		CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	PARAMED ED PRGM	Subtotal	
		14.00	15.00	16.00	17.00	23.00	24.00	
1.00	Administrative and General	6,523	0	0	0	0	794,423	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	1,753,291	2.00
3.00	Physical Therapy	0	0	0	0	0	1,263,672	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	9,031	6.00
7.00	Home Health Aide	0	0	0	0	0	89,309	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	6,523	0	0	0	0	3,909,726	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00
Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs			
		25.00	26.00	27.00	28.00			
1.00	Administrative and General	0	794,423					1.00
2.00	Skilled Nursing Care	0	1,753,291	447,101	2,200,392			2.00
3.00	Physical Therapy	0	1,263,672	322,245	1,585,917			3.00
4.00	Occupational Therapy	0	0	0	0			4.00
5.00	Speech Pathology	0	0	0	0			5.00
6.00	Medical Social Services	0	9,031	2,303	11,334			6.00
7.00	Home Health Aide	0	89,309	22,774	112,083			7.00
8.00	Supplies (see instructions)	0	0	0	0			8.00
9.00	Drugs	0	0	0	0			9.00
10.00	DME	0	0	0	0			10.00
11.00	Home Dialysis Aide Services	0	0	0	0			11.00
12.00	Respiratory Therapy	0	0	0	0			12.00
13.00	Private Duty Nursing	0	0	0	0			13.00
14.00	Clinic	0	0	0	0			14.00
15.00	Health Promotion Activities	0	0	0	0			15.00
16.00	Day Care Program	0	0	0	0			16.00
17.00	Home Delivered Meals Program	0	0	0	0			17.00
18.00	Homemaker Service	0	0	0	0			18.00
19.00	All Others (specify)	0	0	0	0			19.00
20.00	Total (sum of lines 1-19) (2)	0	3,909,726	794,423	3,909,726			20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.			0.255007				21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 140213  
HHA CCN: 147452

Period:  
From 10/01/2013  
To 09/30/2014

Worksheet H-2  
Part II  
Date/Time Prepared:  
2/25/2015 8:07 am  
PPS

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)					
	1.00	2.00					
1.00 Administrative and General	0	1,193	1,490,201	0	513,907	0	1.00
2.00 Skilled Nursing Care	0	0	0	0	1,373,920	0	2.00
3.00 Physical Therapy	0	0	0	0	990,243	0	3.00
4.00 Occupational Therapy	0	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	7,077	0	6.00
7.00 Home Health Aide	0	0	0	0	69,985	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19)	0	1,193	1,490,201		2,955,132	0	20.00
21.00 Total cost to be allocated	0	1,285	512,622		815,980	0	21.00
22.00 Unit cost multiplier	0.000000	1.077117	0.343995		0.276123	0.000000	22.00
Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRSING)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	
	8.00	9.00	10.00	11.00	13.00	14.00	
1.00 Administrative and General	0	0	0	0	42,266	44,830	1.00
2.00 Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00 Physical Therapy	0	0	0	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19)	0	0	0	0	42,266	44,830	20.00
21.00 Total cost to be allocated	0	0	0	0	132,091	6,523	21.00
22.00 Unit cost multiplier	0.000000	0.000000	0.000000	0.000000	3.125231	0.145505	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 140213  
HHA CCN: 147452

Period:  
From 10/01/2013  
To 09/30/2014

Worksheet H-2  
Part II  
Date/Time Prepared:  
2/25/2015 8:07 am  
PPS

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



APPORTIONMENT OF PATIENT SERVICE COSTS				Provider CCN: 140213	Period: From 10/01/2013 To 09/30/2014	Worksheet H-3 Part I Date/Time Prepared: 2/25/2015 8:07 am		
				HHA CCN: 147452	Title XVIII	Home Health Agency I PPS		
Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (col. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 + col. 4)		
	0	1.00	2.00	3.00	4.00	5.00		
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	2.00	2,200,392		2,200,392	10,674	206.15	1.00
2.00	Physical Therapy	3.00	1,585,917	0	1,585,917	6,643	238.74	2.00
3.00	Occupational Therapy	4.00	0	0	0	1,696	0.00	3.00
4.00	Speech Pathology	5.00	0	0	0	331	0.00	4.00
5.00	Medical Social Services	6.00	11,334		11,334	147	77.10	5.00
6.00	Home Health Aide	7.00	112,083		112,083	1,433	78.22	6.00
7.00	Total (sum of lines 1-6)		3,909,726	0	3,909,726	20,924		7.00
Program Visits								
Part B								
Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles			
	0	1.00	2.00	3.00	4.00	5.00		
Limitation Cost Computation								
8.00	Skilled Nursing Care		16974	619	8,745			8.00
9.00	Physical Therapy		16974	351	4,703			9.00
10.00	Occupational Therapy		16974	115	1,256			10.00
11.00	Speech Pathology		16974	5	233			11.00
12.00	Medical Social Services		16974	3	127			12.00
13.00	Home Health Aide		16974	113	1,314			13.00
14.00	Total (sum of lines 8-13)			1,206	16,378			14.00
Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (col. 1 + 2)	Total Charges (From HHA Record)	Ratio (col. 3 + col. 4)		
	0	1.00	2.00	3.00	4.00	5.00		
Supplies and Drugs Cost Computations								
15.00	Cost of Medical Supplies	8.00	0	0	0	22,707	0.000000	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00
Program Visits								
Part B								
Cost Center Description	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Cost of Services Part A	Part B Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		
	6.00	7.00	8.00	9.00	10.00	11.00		
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	619	8,745		127,607	1,802,782		1.00
2.00	Physical Therapy	351	4,703		83,798	1,122,794		2.00
3.00	Occupational Therapy	115	1,256		0	0		3.00
4.00	Speech Pathology	5	233		0	0		4.00
5.00	Medical Social Services	3	127		231	9,792		5.00
6.00	Home Health Aide	113	1,314		8,839	102,781		6.00
7.00	Total (sum of lines 1-6)	1,206	16,378		220,475	3,038,149		7.00
Cost Center Description								
	6.00	7.00	8.00	9.00	10.00	11.00		
Limitation Cost Computation								
8.00	Skilled Nursing Care							8.00
9.00	Physical Therapy							9.00
10.00	Occupational Therapy							10.00
11.00	Speech Pathology							11.00
12.00	Medical Social Services							12.00
13.00	Home Health Aide							13.00
14.00	Total (sum of lines 8-13)							14.00

APPORTIONMENT OF PATIENT SERVICE COSTS				Provider CCN: 140213 HHA CCN: 147452	Period: From 10/01/2013 To 09/30/2014	Worksheet H-3 Part I Date/Time Prepared: 2/25/2015 8:07 am
				Title XVII I	Home Health Agency I	PPS
Cost Center Description	Program Covered Charges			Cost of Services		
	Part A	Part B				
		Not Subject to Deductibles & Co Insurance	Subject to Deductibles & Co Insurance	Part A	Not Subject to Deductibles & Co Insurance	Subject to Deductibles & Co Insurance
	6.00	7.00	8.00	9.00	10.00	11.00
<b>Supplies and Drugs Cost Computations</b>						
15.00	Cost of Medical Supplies					15.00
16.00	Cost of Drugs	216	0		0	16.00
Cost Center Description		Total Program Cost (sum of col.s. 9-10)				
		12.00				
<b>PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION</b>						
<b>Cost Per Visit Computation</b>						
1.00	Skilled Nursing Care	1,930,389				1.00
2.00	Physical Therapy	1,206,592				2.00
3.00	Occupational Therapy	0				3.00
4.00	Speech Pathology	0				4.00
5.00	Medical Social Services	10,023				5.00
6.00	Home Health Aide	111,620				6.00
7.00	Total (sum of lines 1-6)	3,258,624				7.00
Cost Center Description						
		12.00				
<b>Limitation Cost Computation</b>						
8.00	Skilled Nursing Care					8.00
9.00	Physical Therapy					9.00
10.00	Occupational Therapy					10.00
11.00	Speech Pathology					11.00
12.00	Medical Social Services					12.00
13.00	Home Health Aide					13.00
14.00	Total (sum of lines 8-13)					14.00

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 140213 HHA CCN: 147452	Period: From 10/01/2013 To 09/30/2014	Worksheet H-3 Part II Date/Time Prepared: 2/25/2015 8:07 am PPS
		Title XVIII	Home Health Agency I	

Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated	
	0	1.00	2.00	3.00	4.00	
<b>PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS</b>						
1.00	Physical Therapy	66.00	0.344137	0	0	col. 2, line 2.00 1.00
2.00	Occupational Therapy	67.00	0.207264	0	0	col. 2, line 3.00 2.00
3.00	Speech Pathology	68.00	0.000000	0	0	col. 2, line 4.00 3.00
4.00	Cost of Medical Supplies	71.00	0.529844	0	0	col. 2, line 15.00 4.00
5.00	Cost of Drugs	73.00	0.324595	0	0	col. 2, line 16.00 5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 140213 HHA CCN: 147452	Period: From 10/01/2013 To 09/30/2014	Worksheet H-4 Part I-II Date/Time Prepared: 2/25/2015 8:07 am
		Title XVII I	Home Health Agency I	PPS
		Part A	Part B	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		1.00	2.00	3.00
<b>PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES</b>				
Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0
2.00	Total charges	252,852	3,400,969	0
Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(b)	0	0	0
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000
6.00	Total customary charges (see instructions)	252,852	3,400,969	0
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	252,852	3,400,969	0
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0
9.00	Primary payer amounts	0	0	0
			Part A Services	Part B Services
			1.00	2.00
<b>PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT</b>				
10.00	Total reasonable cost (see instructions)		0	0
11.00	Total PPS Reimbursement - Full Episodes without Outliers		147,125	2,270,984
12.00	Total PPS Reimbursement - Full Episodes with Outliers		14,330	58,601
13.00	Total PPS Reimbursement - LUPA Episodes		120	36,382
14.00	Total PPS Reimbursement - PEP Episodes		7,503	70,187
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		3,733	17,138
16.00	Total PPS Outlier Reimbursement - PEP Episodes		601	841
17.00	Total Other Payments		0	0
18.00	DME Payments		0	0
19.00	Oxygen Payments		0	0
20.00	Prosthetic and Orthotic Payments		0	0
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	0
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		173,412	2,454,133
23.00	Excess reasonable cost (from line 8)		0	0
24.00	Subtotal (line 22 minus line 23)		173,412	2,454,133
25.00	Coinsurance billed to program patients (from your records)			0
26.00	Net cost (line 24 minus line 25)		173,412	2,454,133
27.00	Reimbursable bad debts (from your records)			0
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			0
29.00	Total costs - current cost reporting period (line 26 plus line 27)		173,412	2,454,133
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0
31.00	Subtotal (line 29 plus/minus line 30)		173,412	2,454,133
31.01	Sequestration adjustment (see instructions)		3,468	49,083
32.00	Interim payments (see instructions)		169,943	2,405,050
33.00	Tentative settlement (for contractor use only)		0	0
34.00	Balance due provider/program line 31 minus lines 31.01, 32 and 33		1	0
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		0	0

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

Provider CCN: 140213

Period: From 10/01/2013

Worksheet H-5

HHA CCN: 147452

To 09/30/2014

Date/Time Prepared: 2/25/2015 8:07 am

Home Health Agency I

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		169,943		2,405,050	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		169,943		2,405,050	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		1		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		169,944		2,405,050	7.00
		0		Contractor Number	NPR Date (Mo/Day/Yr)	
				1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 140213	Period: From 10/01/2013 To 09/30/2014	Worksheet L Parts I-III Date/Time Prepared: 2/25/2015 8:07 am
		Title XVIII	Hospital	PPS
				1.00
<b>PART I - FULLY PROSPECTIVE METHOD</b>				
<b>CAPITAL FEDERAL AMOUNT</b>				
1.00	Capital DRG other than outlier		4,130,438	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		216,742	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)		167.44	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		3.13	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		15.54	8.00
9.00	Sum of lines 7 and 8		18.67	9.00
10.00	Allowable disproportionate share percentage (see instructions)		3.85	10.00
11.00	Disproportionate share adjustment (line 10 times the sum of lines 1 and 1.01)		159,022	11.00
12.00	Total prospective capital payments (sum of lines 1, 1.01, 2, 2.01, 6 and 11)		4,506,202	12.00
				1.00
<b>PART II - PAYMENT UNDER REASONABLE COST</b>				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
				1.00
<b>PART III - COMPUTATION OF EXCEPTION PAYMENTS</b>				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00