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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 14-0213	Period: From 10/01/2015 To 09/30/2016	Worksheet S Parts I-III Date/Time Prepared: 2/27/2017 8:39 am

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 2/27/2017 Time: 8:39 am
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

5. [1] Cost Report Status
   (1) As Submitted
   (2) Settled without Audit
   (3) Settled with Audit
   (4) Reopened
   (5) Amended
6. Date Received:
7. Contractor No.
8. [N] Initial Report for this Provider CCN
9. [N] Final Report for this Provider CCN
10. NPR Date:
11. Contractor's Vendor Code: 4
12. [0] If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by SILVER CROSS HOSPITAL (14-0213) for the cost reporting period beginning 10/01/2015 and ending 09/30/2016 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	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	111,635	133,987	763,815	0	1.00
2.00	Subprovider - IPF	0	50,618	0		0	2.00
3.00	Subprovider - IRF	0	-38,968	0		0	3.00
4.00	SUBPROVIDER I						4.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
8.00	NURSING FACILITY	0				0	8.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
12.00	CMHC I	0		0		0	12.00
200.00	Total	0	123,285	133,987	763,815	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-2 Part I | Date/Time Prepared: 2/27/2017 8:38 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) V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	SILVER CROSS HOSPITAL	140213	16974	1	07/01/1966	N	P	P	3.00
4.00	Subprovider - IPF	SCH - MENTAL HEALTH CARE UNIT	14S213	16974	4	04/01/1991	N	P	P	4.00
5.00	Subprovider - IRF	SCH - REHAB	14T213	16974	5	10/01/2000	N	P	P	5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	SCH HOME HEALTH	147452	16974		04/01/1994	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
17.10	Hospital-Based (CORF) I									17.10
18.00	Renal Dialysis									18.00
18.01										18.01
18.02										18.02
19.00	Other									19.00

		From: 1.00	To: 2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	10/01/2015	09/30/2016	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 §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.	Y	N	22.00
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)	N	Y	22.01
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.	N	N	22.02
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.	N	N	22.03
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.	1	N	23.00

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	7,131	3,202	0	0	1,470	0	24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-2 Part I | Date/Time Prepared: 2/27/2017 8:38 am

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	74	51	0	0	33		25.00

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

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

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

		V	XVIII	XIX	
		1.00	2.00	3.00	
	Prospective Payment System (PPS)-Capital				
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	Y	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.	N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y for yes or "N" for no.	N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N	48.00
	Teaching Hospitals				
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.	N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.	N			59.00
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	61.00
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

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		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period.(see instructions).		0.00	0.00			61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00			61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00			61.06

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

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

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

		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-2 Part I Date/Time Prepared: 2/27/2017 8:38 am

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

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

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

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

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

		V	XIX	
		1.00	2.00	
	Title V and XIX Services			
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00
	Rural Providers			
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	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

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

		1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo)for the current cost reporting period? Enter "Y" for yes or "N" for no.	N	110.00

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

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

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

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

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-2 Part I Date/Time Prepared: 2/27/2017 8:38 am

							1.00	
	Multicampus							
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.						N	165.00
		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00
							1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act							
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.						Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)						0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)							168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.25	169.00
						Beginning	Ending	
						1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)					10/01/2015	09/30/2016	170.00
						1.00	2.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)					N	0	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-0213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-2 Part II Date/Time Prepared: 2/27/2017 8:38 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 Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N		9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N		11.00

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	02/16/2017	Y	02/16/2017	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE | Provider CCN: 14-0213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-2 Part II Date/Time Prepared: 2/27/2017 8:38 am

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-0213	Period: From 10/01/2015 To 09/30/2016	Worksheet S-2 Part II Date/Time Prepared: 2/27/2017 8:38 am

		3.00		
	Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	VICE PRESIDENT 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: 14-0213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-3 Part I Date/Time Prepared: 2/27/2017 8:38 am

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	223	81,618	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	81,618	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	28	10,248	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	91,866	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	20	7,320		0	16.00
17.00	SUBPROVIDER - IRF	41.00	25	9,150		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)		296				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: 14-0213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-3 Part I | Date/Time Prepared: 2/27/2017 8:38 am

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	26,604	4,721	57,665			1.00
2.00	HMO and other (see instructions)	6,077	5,731				2.00
3.00	HMO IPF Subprovider	12	982				3.00
4.00	HMO IRF Subprovider	524	76				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)	26,604	4,721	57,665			7.00
8.00	INTENSIVE CARE UNIT	3,379	583	7,120			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		623	7,605			13.00
14.00	Total (see instructions)	29,983	5,927	72,390	0.00	1,698.10	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	1,415	627	6,211	0.00	27.50	16.00
17.00	SUBPROVIDER - IRF	5,214	82	8,075	0.00	52.40	17.00
18.00	SUBPROVIDER		0	0	0.00	0.00	18.00
19.00	SKILLED NURSING FACILITY	0	0	0	0.00	0.00	19.00
20.00	NURSING FACILITY		0	0	0.00	0.00	20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	18,618	0	27,354	0.00	23.60	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	1,801.60	27.00
28.00	Observation Bed Days		1,208	8,703			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	145	1,766			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-0213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-3 Part I | Date/Time Prepared: 2/27/2017 8:38 am

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	6,877	3,467	18,807	1.00
2.00	HMO and other (see instructions)			1,385	0		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	6,877	3,467	18,807	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	188	360	975	16.00
17.00	SUBPROVIDER - IRF	0.00	0	387	10	595	17.00
18.00	SUBPROVIDER	0.00	0		0	0	18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY	0.00					20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC	0.00					25.00
25.10	CMHC - CORF	0.00					25.10
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-3 Part II Date/Time Prepared: 2/27/2017 8:38 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	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	119,267,105	0	119,267,105	3,761,741.00	31.71	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician and Non Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B for hospital-based RHC and FQHC services		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office and/or related organization personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		7,857,516	0	7,857,516	230,098.00	34.15	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		1,930,460	0	1,930,460	31,727.00	60.85	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		191,182	0	191,182	1,321.00	144.73	13.00
14.00	Home office and/or related orgainzation salaries and wage-related costs		6,104,979	0	6,104,979	18,928.00	322.54	14.00
14.01	Home office salaries		0	0	0	0.00	0.00	14.01
14.02	Related organization salaries		0	0	0	0.00	0.00	14.02
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
	WAGE-RELATED COSTS							
17.00	Wage-related costs (core) (see instructions)		30,726,350	0	30,726,350			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		2,167,074	0	2,167,074			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related		0	0	0			25.50
25.51	Related orgainzation wage-related		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	852,408	0	852,408	22,133.00	38.51	26.00
27.00	Administrative & General	5.00	16,580,216	-367,664	16,212,552	503,465.00	32.20	27.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-3 Part II Date/Time Prepared: 2/27/2017 8:38 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	
28.00	Administrative & General under contract (see inst.)		244,514	0	244,514	2,008.00	121.77	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	2,878,783	0	2,878,783	113,587.00	25.34	30.00
31.00	Laundry & Linen Service	8.00	98,606	0	98,606	6,473.00	15.23	31.00
32.00	Housekeeping	9.00	2,349,593	0	2,349,593	162,655.00	14.45	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	2,164,154	-1,670,354	493,800	71,081.00	6.95	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	1,670,354	1,670,354	71,081.00	23.50	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	4,013,099	0	4,013,099	127,786.00	31.40	38.00
39.00	Central Services and Supply	14.00	1,513,904	-879,825	634,079	38,789.00	16.35	39.00
40.00	Pharmacy	15.00	3,069,099	0	3,069,099	67,025.00	45.79	40.00
41.00	Medical Records & Medical Records Library	16.00	2,177,849	0	2,177,849	84,564.00	25.75	41.00
42.00	Social Service	17.00	0	367,664	367,664	12,480.00	29.46	42.00
43.00	Other General Service	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-3 Part III Date/Time Prepared: 2/27/2017 8:38 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	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		119,511,619	0	119,511,619	3,763,749.00	31.75	1.00
2.00	Excluded area salaries (see instructions)		7,857,516	0	7,857,516	230,098.00	34.15	2.00
3.00	Subtotal salaries (line 1 minus line 2)		111,654,103	0	111,654,103	3,533,651.00	31.60	3.00
4.00	Subtotal other wages & related costs (see inst.)		8,226,621	0	8,226,621	51,976.00	158.28	4.00
5.00	Subtotal wage-related costs (see inst.)		30,726,350	0	30,726,350	0.00	27.52	5.00
6.00	Total (sum of lines 3 thru 5)		150,607,074	0	150,607,074	3,585,627.00	42.00	6.00
7.00	Total overhead cost (see instructions)		35,942,225	-879,825	35,062,400	1,283,127.00	27.33	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 14-0213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-3 Part IV Date/Time Prepared: 2/27/2017 8:38 am

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	4,882,493	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	14,253,343	8.00
8.01	Health Insurance (Self Funded without a Third Party Administrator)	0	8.01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	0	8.02
8.03	Health Insurance (Purchased)	0	8.03
9.00	Prescription Drug Plan	0	9.00
10.00	Dental, Hearing and Vision Plan	689,798	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	122,587	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)	981,460	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	2,715,710	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	8,815,035	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	65,000	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))	0	21.00
22.00	Day Care Cost and Allowances	0	22.00
23.00	Tuition Reimbursement	367,998	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	32,893,424	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST | Provider CCN: 14-0213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-3 Part V Date/Time Prepared: 2/27/2017 8:38 am

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	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: 14-0213 | Component CCN: 14-7452 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-4 | Date/Time Prepared: 2/27/2017 8:38 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	2,615	0	0	2,615	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	1,191.00	18.00	377.00	1,586.00	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	7.66	0.00	7.66	3.00
4.00	Director(s) and Assistant Director(s)			0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel			0.00	0.00	0.00	5.00
6.00	Direct Nursing Service			14.81	0.00	14.81	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			0.00	84.20	84.20	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			0.00	1.60	1.60	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			0.04	4.60	4.64	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	Other (specify)			0.00	0.00	0.00	18.00
	HOME HEALTH AGENCY CBSA CODES						
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			1			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			16974			20.00
		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	8,202	710	197	670	9,779	21.00
22.00	Skilled Nursing Visit Charges	1,975,042	170,968	47,438	161,336	2,354,784	22.00
23.00	Physical Therapy Visits	4,900	316	23	354	5,593	23.00
24.00	Physical Therapy Visit Charges	1,106,194	71,353	5,193	79,933	1,262,673	24.00
25.00	Occupational Therapy Visits	1,494	158	4	111	1,767	25.00
26.00	Occupational Therapy Visit Charges	337,345	35,676	903	25,064	398,988	26.00
27.00	Speech Pathology Visits	171	25	0	10	206	27.00
28.00	Speech Pathology Visit Charges	40,980	5,991	0	2,397	49,368	28.00
29.00	Medical Social Service Visits	34	7	1	8	50	29.00
30.00	Medical Social Service Visit Charges	11,212	2,308	330	2,638	16,488	30.00
31.00	Home Health Aide Visits	932	230	3	58	1,223	31.00
32.00	Home Health Aide Visit Charges	137,237	33,868	442	8,541	180,088	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	15,733	1,446	228	1,211	18,618	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)	3,608,010	320,164	54,306	279,909	4,262,389	35.00
36.00	Total Number of Episodes (standard/non outlier)	809		79	61	949	36.00
37.00	Total Number of Outlier Episodes		31		13	44	37.00
38.00	Total Non-Routine Medical Supply Charges	34,910	2,282	7,502	1,392	46,086	38.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-0213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet S-10 | Date/Time Prepared: 2/27/2017 8:38 am

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.259677	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	33,280,000	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	129,176,000	6.00
7.00	Medicaid cost (line 1 times line 6)	33,544,036	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)	264,036	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	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 , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	264,036	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Charity care charges for the entire facility (see instructions)	12,379,504	2,519,951	14,899,455	20.00
21.00	Cost of patients approved for charity care (line 1 times line 20)	3,214,672	654,373	3,869,045	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)	3,214,672	654,373	3,869,045	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)	10,537,000	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)	860,760	27.00
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)	9,676,240	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)	2,512,697	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	6,381,742	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	6,645,778	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A | Date/Time Prepared: 2/27/2017 8:38 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		56,482,233	56,482,233	-25,341,345	31,140,888	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	15,284,627	15,284,627	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	852,408	33,801,156	34,653,564	0	34,653,564	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	16,580,216	43,035,891	59,616,107	6,696,257	66,312,364	5.00
7.00	00700	OPERATION OF PLANT	2,878,783	5,900,840	8,779,623	0	8,779,623	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	98,606	39,478	138,084	0	138,084	8.00
9.00	00900	HOUSEKEEPING	2,349,593	1,280,055	3,629,648	0	3,629,648	9.00
10.00	01000	DIETARY	2,164,154	2,698,429	4,862,583	-3,753,076	1,109,507	10.00
11.00	01100	CAFETERIA	0	0	0	3,753,076	3,753,076	11.00
13.00	01300	NURSING ADMINISTRATION	4,013,099	38,816	4,051,915	-166	4,051,749	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,513,904	2,090,527	3,604,431	-2,691,039	913,392	14.00
15.00	01500	PHARMACY	3,069,099	13,540,698	16,609,797	-11,488,661	5,121,136	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,177,849	2,008,496	4,186,345	0	4,186,345	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	367,664	367,664	17.00
23.00	02300	PARAMED ED PRGM	296,244	383,495	679,739	-1,548	678,191	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	20,068,096	3,160,395	23,228,491	4,368,898	27,597,389	30.00
31.00	03100	INTENSIVE CARE UNIT	5,587,382	1,178,394	6,765,776	-216,227	6,549,549	31.00
40.00	04000	SUBPROVIDER - IPF	1,920,143	373,234	2,293,377	40,145	2,333,522	40.00
41.00	04100	SUBPROVIDER - IRF	3,742,618	591,196	4,333,814	51,882	4,385,696	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	8,965,623	808,424	9,774,047	-7,303,506	2,470,541	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	9,347,246	33,681,715	43,028,961	-23,295,152	19,733,809	50.00
51.00	05100	RECOVERY ROOM	1,283,817	103,966	1,387,783	-5,835	1,381,948	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	851,494	851,494	3,396,714	4,248,208	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7,822,806	10,462,047	18,284,853	-6,301,694	11,983,159	54.00
54.01	05401	ULTRASOUND	1,126,812	201,199	1,328,011	-2,561	1,325,450	54.01
57.00	05700	CT SCAN	1,130,587	915,410	2,045,997	-26,365	2,019,632	57.00
58.00	05800	MRI	635,829	576,188	1,212,017	-32	1,211,985	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	3,800,345	5,716,728	9,517,073	33,579	9,550,652	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	265,045	1,608,944	1,873,989	0	1,873,989	63.00
65.00	06500	RESPIRATORY THERAPY	1,584,666	351,320	1,935,986	84,706	2,020,692	65.00
65.01	06501	SLEEP LAB	201,717	164,612	366,329	110,000	476,329	65.01
66.00	06600	PHYSICAL THERAPY	1,260,029	367,920	1,627,949	-1,976	1,625,973	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,214,498	404,806	2,619,304	-6,851	2,612,453	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,255,172	146,612	1,401,784	159,981	1,561,765	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	226,485	26,293	252,778	841,038	1,093,816	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	14,514,547	14,514,547	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	19,086,994	19,086,994	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	11,451,256	11,451,256	73.00
74.00	07400	RENAL DIALYSIS	436,506	154,939	591,445	11,242	602,687	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	463,945	154,409	618,354	-25,911	592,443	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	7,211,306	1,719,088	8,930,394	320,314	9,250,708	91.00
91.01	09101	OP MENTAL HEALTH	476,554	14,211	490,765	0	490,765	91.01
91.02	09102	DIABETES CENTER	347,412	6,453	353,865	-86,508	267,357	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	1,883,929	1,359,241	3,243,170	-24,467	3,218,703	101.00
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	119,252,523	226,399,352	345,651,875	0	345,651,875	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	14,582	0	14,582	0	14,582	190.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A | Date/Time Prepared: 2/27/2017 8:38 am

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		TOTAL (SUM OF LINES 118-199)	119,267,105	226,399,352	345,666,457	0	345,666,457	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A | Date/Time Prepared: 2/27/2017 8:38 am

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-11,881,738	19,259,150		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	15,284,627		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-71,618	34,581,946		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-17,750,474	48,561,890		5.00
7.00	00700	OPERATION OF PLANT	-170	8,779,453		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	138,084		8.00
9.00	00900	HOUSEKEEPING	-56	3,629,592		9.00
10.00	01000	DIETARY	0	1,109,507		10.00
11.00	01100	CAFETERIA	-2,324,959	1,428,117		11.00
13.00	01300	NURSING ADMINISTRATION	0	4,051,749		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-2,588	910,804		14.00
15.00	01500	PHARMACY	0	5,121,136		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-4,842	4,181,503		16.00
17.00	01700	SOCIAL SERVICE	0	367,664		17.00
23.00	02300	PARAMED ED PRGM	-211,897	466,294		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-1,204,842	26,392,547		30.00
31.00	03100	INTENSIVE CARE UNIT	-50,912	6,498,637		31.00
40.00	04000	SUBPROVIDER - IPF	-41,825	2,291,697		40.00
41.00	04100	SUBPROVIDER - IRF	-103,686	4,282,010		41.00
42.00	04200	SUBPROVIDER	0	0		42.00
43.00	04300	NURSERY	0	2,470,541		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0		44.00
45.00	04500	NURSING FACILITY	0	0		45.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	-11,933	19,721,876		50.00
51.00	05100	RECOVERY ROOM	0	1,381,948		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	4,248,208		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,516,804	15,499,963		54.00
54.01	05401	ULTRASOUND	0	1,325,450		54.01
57.00	05700	CT SCAN	-25	2,019,607		57.00
58.00	05800	MRI	0	1,211,985		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	-27,072	9,523,580		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	1,873,989		63.00
65.00	06500	RESPIRATORY THERAPY	-75,809	1,944,883		65.00
65.01	06501	SLEEP LAB	-110,000	366,329		65.01
66.00	06600	PHYSICAL THERAPY	0	1,625,973		66.00
67.00	06700	OCCUPATIONAL THERAPY	-25	2,612,428		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	-197,945	1,363,820		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	-850,800	243,016		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	14,514,547		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	19,086,994		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	11,451,256		73.00
74.00	07400	RENAL DIALYSIS	-6,466	596,221		74.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	09000	CLINIC	7,374	599,817		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	-743,085	8,507,623		91.00
91.01	09101	OP MENTAL HEALTH	-108	490,657		91.01
91.02	09102	DIABETES CENTER	-1,705	265,652		91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				92.00
		OTHER REIMBURSABLE COST CENTERS				
94.00	09400	HOME PROGRAM DIALYSIS	0	0		94.00
99.00	09900	CMHC	0	0		99.00
99.10	09910	CORF	0	0		99.10
101.00	10100	HOME HEALTH AGENCY	0	3,218,703		101.00
		SPECIAL PURPOSE COST CENTERS				
109.00	10900	PANCREAS ACQUISITION	0	0		109.00
110.00	11000	INTESTINAL ACQUISITION	0	0		110.00
111.00	11100	ISLET ACQUISITION	0	0		111.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-32,150,402	313,501,473		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	14,582		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
200.00		TOTAL (SUM OF LINES 118-199)	-32,150,402	313,516,055		200.00

RECLASSIFICATIONS | Provider CCN: 14-0213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-6 | Date/Time Prepared: 2/27/2017 8:38 am

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - STERILE PROCESSING					
1.00	ADULTS & PEDIATRICS	30.00	12,318	22,072		1.00
2.00	OPERATING ROOM	50.00	788,323	1,412,584		2.00
3.00	DELIVERY ROOM & LABOR ROOM	52.00	55,429	99,322		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	6,159	11,036		4.00
5.00	CLINIC	90.00	3,519	6,306		5.00
6.00	EMERGENCY	91.00	14,077	25,225		6.00
	0		879,825	1,576,545		
	C - CAPITAL INSURANCE					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	246,916		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	268,301		2.00
	0		0	515,217		
	D - CHARGEABLE DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	11,451,256		1.00
	0		0	11,451,256		
	E - MALPRACTICE INSURANCE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	9,788,417		1.00
	0		0	9,788,417		
	F - DEPRECIATION					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	15,037,711		1.00
	0		0	15,037,711		
	G - PHYSICIAN FEES					
1.00	ADULTS & PEDIATRICS	30.00	0	1,204,717		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	76,250		2.00
3.00	SUBPROVIDER - IPF	40.00	0	41,800		3.00
4.00	SUBPROVIDER - IRF	41.00	0	102,655		4.00
5.00	OPERATING ROOM	50.00	0	15,000		5.00
6.00	LABORATORY	60.00	0	34,000		6.00
7.00	RESPIRATORY THERAPY	65.00	0	88,332		7.00
8.00	SLEEP LAB	65.01	0	110,000		8.00
9.00	ELECTROCARDIOLOGY	69.00	0	160,000		9.00
10.00	ELECTROENCEPHALOGRAPHY	70.00	0	850,800		10.00
11.00	RENAL DIALYSIS	74.00	0	12,600		11.00
12.00	EMERGENCY	91.00	0	365,000		12.00
13.00	DIABETES CENTER	91.02	0	5,000		13.00
14.00	HOME HEALTH AGENCY	101.00	0	35,000		14.00
	0		0	3,101,154		
	H - LABOR AND DELIVERY					
1.00	ADULTS & PEDIATRICS	30.00	3,647,935	0		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	3,642,031	0		2.00
	0		7,289,966	0		
	I - SOCIAL SERVICES					
1.00	SOCIAL SERVICE	17.00	367,664	0		1.00
	0		367,664	0		
	K - CHARGEABLE SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	14,514,547		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	100,983		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
	0		0	14,615,530		

RECLASSIFICATIONS | Provider CCN: 14-0213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-6 | Date/Time Prepared: 2/27/2017 8:38 am

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	L - DIABETES MANAGEMENT					
1.00	ADULTS & PEDIATRICS	30.00	89,839	1,669		1.00
	0		89,839	1,669		
	M - DIETARY RECLASS					
1.00	CAFETERIA	11.00	1,670,354	2,082,722		1.00
	0		1,670,354	2,082,722		
	N - IMPLANTABLE DEVICES					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	19,086,994		1.00
2.00		0.00	0	0		2.00
	0		0	19,086,994		
500.00	Grand Total: Increases		10,297,648	77,257,215		500.00

RECLASSIFICATIONS | Provider CCN: 14-0213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-6 | Date/Time Prepared: 2/27/2017 8:38 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - STERILE PROCESSING						
1.00	CENTRAL SERVICES & SUPPLY	14.00	879,825	1,576,545	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
	0		879,825	1,576,545			
	C - CAPITAL INSURANCE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	515,217	9		1.00
2.00		0.00	0	0	0		2.00
	0		0	515,217			
	D - CHARGEABLE DRUGS						
1.00	PHARMACY	15.00	0	11,451,256	0		1.00
	0		0	11,451,256			
	E - MALPRACTICE INSURANCE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	9,788,417	9		1.00
	0		0	9,788,417			
	F - DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	15,037,711	9		1.00
	0		0	15,037,711			
	G - PHYSICIAN FEES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	3,093,780	0		1.00
2.00	CLINIC	90.00	0	7,374	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
	0		0	3,101,154			
	H - LABOR AND DELIVERY						
1.00	NURSERY	43.00	7,289,966	0	0		1.00
2.00		0.00	0	0	0		2.00
	0		7,289,966	0			
	I - SOCIAL SERVICES						
1.00	ADMINISTRATIVE & GENERAL	5.00	367,664	0	0		1.00
	0		367,664	0			
	K - CHARGEABLE SUPPLIES						
1.00	NURSING ADMINISTRATION	13.00	0	166	0		1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	234,669	0		2.00
3.00	PHARMACY	15.00	0	37,405	0		3.00
4.00	PARAMED ED PRGM	23.00	0	1,548	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	609,652	0		5.00
6.00	INTENSIVE CARE UNIT	31.00	0	292,477	0		6.00
7.00	SUBPROVIDER - IPF	40.00	0	1,655	0		7.00
8.00	SUBPROVIDER - IRF	41.00	0	50,773	0		8.00
9.00	NURSERY	43.00	0	13,540	0		9.00
10.00	OPERATING ROOM	50.00	0	9,769,500	0		10.00
11.00	RECOVERY ROOM	51.00	0	5,835	0		11.00
12.00	DELIVERY ROOM & LABOR ROOM	52.00	0	400,068	0		12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	2,973,454	0		13.00
14.00	ULTRASOUND	54.01	0	2,561	0		14.00
15.00	CT SCAN	57.00	0	26,365	0		15.00
16.00	MRI	58.00	0	32	0		16.00
17.00	LABORATORY	60.00	0	421	0		17.00
18.00	RESPIRATORY THERAPY	65.00	0	3,626	0		18.00
19.00	PHYSICAL THERAPY	66.00	0	1,976	0		19.00
20.00	OCCUPATIONAL THERAPY	67.00	0	6,851	0		20.00
21.00	ELECTROCARDIOLOGY	69.00	0	19	0		21.00
22.00	ELECTROENCEPHALOGRAPHY	70.00	0	9,762	0		22.00
23.00	RENAL DIALYSIS	74.00	0	1,358	0		23.00
24.00	CLINIC	90.00	0	28,362	0		24.00
25.00	EMERGENCY	91.00	0	83,988	0		25.00
26.00	HOME HEALTH AGENCY	101.00	0	59,467	0		26.00
	0		0	14,615,530			

RECLASSIFICATIONS | Provider CCN: 14-0213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-6 | Date/Time Prepared: 2/27/2017 8:38 am

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	L - DIABETES MANAGEMENT						
1.00	DIABETES CENTER	91.02	89,839	1,669	0		1.00
	0		89,839	1,669			
	M - DIETARY RECLASS						
1.00	DIETARY	10.00	1,670,354	2,082,722	0		1.00
	0		1,670,354	2,082,722			
	N - IMPLANTABLE DEVICES						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	3,345,435	0		1.00
2.00	OPERATING ROOM	50.00	0	15,741,559	0		2.00
	0		0	19,086,994			
500.00	Grand Total: Decreases		10,297,648	77,257,215			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-7 Part I Date/Time Prepared: 2/27/2017 8:38 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	14,801,161	5,039,083	0	5,039,083	0	1.00
2.00	Land Improvements	13,585,486	0	0	0	0	2.00
3.00	Buildings and Fixtures	333,260,805	0	0	0	55	3.00
4.00	Building Improvements	3,150,783	393,989	0	393,989	0	4.00
5.00	Fixed Equipment	13,714,362	3,130,488	0	3,130,488	0	5.00
6.00	Movable Equipment	201,021,802	12,389,286	0	12,389,286	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	579,534,399	20,952,846	0	20,952,846	55	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	579,534,399	20,952,846	0	20,952,846	55	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	19,840,244	0	1.00
2.00	Land Improvements	13,585,486	0	2.00
3.00	Buildings and Fixtures	333,260,750	0	3.00
4.00	Building Improvements	3,544,772	0	4.00
5.00	Fixed Equipment	16,844,850	0	5.00
6.00	Movable Equipment	213,411,088	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	600,487,190	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	600,487,190	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-7 Part II | Date/Time Prepared: 2/27/2017 8:38 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	26,543,578	175,000	19,155,781	10,500,000	107,874	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	26,543,578	175,000	19,155,781	10,500,000	107,874	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	56,482,233	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	2.00
3.00	Total (sum of lines 1-2)	0	56,482,233	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-7 Part III | Date/Time Prepared: 2/27/2017 8:38 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	387,076,102	0	387,076,102	0.644603	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	213,411,088	0	213,411,088	0.355397	0	2.00
3.00	Total (sum of lines 1-2)	600,487,190	0	600,487,190	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	564,346	175,000	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	15,284,627	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	15,848,973	175,000	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	7,911,930	10,500,000	107,874	0	19,259,150	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	15,284,627	2.00
3.00	Total (sum of lines 1-2)	7,911,930	10,500,000	107,874	0	34,543,777	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-8 | Date/Time Prepared: 2/27/2017 8:38 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-6,016,700			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	1,751,570			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	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
33.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-8 | Date/Time Prepared: 2/27/2017 8:38 am

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.01	1996 DSR INTEXP. ADD ON	A	14,351	CAP REL COSTS-BLDG & FIXT	1.00	9	33.01
33.02	OTHER REVENUE-CENTRAL SUPPLY	B	-2,588	CENTRAL SERVICES & SUPPLY	14.00	0	33.02
33.03	TELEPHONE BENEFITS	B	-19,092	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.03
38.00	PHYSICIANS	A	-224,122	ADMINISTRATIVE & GENERAL	5.00	0	38.00
39.00	CONTRIBUTIONS EXPENSE	B	-70,254	ADMINISTRATIVE & GENERAL	5.00	9	39.00
40.00	BAD DEBTS	A	1,240,831	ADMINISTRATIVE & GENERAL	5.00	0	40.00
41.00	AHA & IHA DUES-POLITICAL LOBBY	B	-41,731	ADMINISTRATIVE & GENERAL	5.00	0	41.00
42.00	OTHER REV A & G	A	-1,685,013	ADMINISTRATIVE & GENERAL	5.00	0	42.00
43.00	TELEPHONE COSTS	A	-68,412	ADMINISTRATIVE & GENERAL	5.00	0	43.00
44.00	COMMUNITY RELATIONS	A	-1,324,108	ADMINISTRATIVE & GENERAL	5.00	0	44.00
45.01	OTHER REV-EMPLOYEE BENEFIS	B	-52,526	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	45.01
45.02	OTHER REV-OPERATION & PLANT	B	-170	OPERATION OF PLANT	7.00	0	45.02
45.04	OTHER REV-CAFÉ'-EMP & GUESTS	B	-2,320,273	CAFETERIA	11.00	0	45.04
45.05	OTHER REV-VENDING MACHINES	B	-4,686	CAFETERIA	11.00	0	45.05
45.06	OTHER REV-PARAMED ED PROGRAM	B	-211,897	PARAMED ED PRGM	23.00	0	45.06
45.07	OTHER REV-A & P	B	-125	ADULTS & PEDIATRICS	30.00	0	45.07
45.08	OTHER REV-PSYCH	B	-108	OP MENTAL HEALTH	91.01	0	45.08
45.11	OTHER REV-RADILOGY	B	-6,235	RADIOLOGY-DIAGNOSTIC	54.00	0	45.11
45.12	OTHER REV-LAB	B	-1,165	LABORATORY	60.00	0	45.12
45.13	OTHER REV - CT SCAN	B	-25	CT SCAN	57.00	0	45.13
45.15	OTHER REV-CARDIAC CATH	B	-37,945	ELECTROCARDIOLOGY	69.00	0	45.15
45.16	OTHER REV-ER	B	-427,326	EMERGENCY	91.00	0	45.16
45.19	OTHER REV-DIABETES	B	-1,050	DIABETES CENTER	91.02	0	45.19
45.20	INVESTMENT INCOME	B	-11,243,851	CAP REL COSTS-BLDG & FIXT	1.00	11	45.20
45.22	OTHER REV-MED REC	A	-4,842	MEDICAL RECORDS & LIBRARY	16.00	0	45.22
45.24	OTHER REV-PSYCH	B	-25	SUBPROVIDER - IPF	40.00	0	45.24
45.25	OTHER REV-OCCUPATIONAL THERAPY	B	-25	OCCUPATIONAL THERAPY	67.00	0	45.25
45.27	OTHER REV-ENVIRONMENTAL SERVICES	B	-56	HOUSEKEEPING	9.00	0	45.27
45.32	ADMINISTRATIVE MISC. EXPENSE	B	-247,717	ADMINISTRATIVE & GENERAL	5.00	0	45.32
45.34	OTHER REV-REHAB	A	-1,031	SUBPROVIDER - IRF	41.00	0	45.34
45.35	PROVIDER TAX ASSESSMENT IN A&G	B	-10,491,818	ADMINISTRATIVE & GENERAL	5.00	0	45.35
46.00	OTHER REV - CAPITAL EXPENSE	B	-652,238	CAP REL COSTS-BLDG & FIXT	1.00	9	46.00
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-32,150,402				50.00

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME OFFICE COSTS | Provider CCN: 14-0213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-8-1 | Date/Time Prepared: 2/27/2017 8:38 am

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	MANAGEMENT FEE	7,022,695	8,794,164	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	JOINT VENTURE OPERATING EXPE	3,523,039	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.			10,545,734	8,794,164	5.00

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

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

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

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

6.00	G	SILVER CROSS HO	100.00	SILVER CROSS HO	100.00	6.00
7.00	C	UCMS/SCH ONC JV	60.00	UCMS/SCH ONC JV	60.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:	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: 14-0213	Period: From 10/01/2015 To 09/30/2016	Worksheet A-8-1 Date/Time Prepared: 2/27/2017 8:38 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	-1,771,469	0		1.00
2.00	3,523,039	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	1,751,570			5.00

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

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

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT | Provider CCN: 14-0213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet A-8-2 | Date/Time Prepared: 2/27/2017 8:38 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	3,066,661	3,066,661	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	1,204,717	1,204,717	0	177,200	0	2.00
3.00	31.00	INTENSIVE CARE UNIT	76,250	0	76,250	154,100	342	3.00
4.00	40.00	SUBPROVIDER - IPF	41,800	41,800	0	154,100	0	4.00
5.00	41.00	SUBPROVIDER - IRF	102,655	102,655	0	208,000	0	5.00
6.00	50.00	OPERATING ROOM	15,000	10,000	5,000	177,200	36	6.00
7.00	65.00	RESPIRATORY THERAPY	88,332	70,000	18,332	177,200	147	7.00
8.00	69.00	ELECTROCARDIOLOGY	160,000	160,000	0	177,200	0	8.00
9.00	70.00	ELECTROENCEPHALOGRAPHY	850,800	850,800	0	177,200	0	9.00
10.00	74.00	RENAL DIALYSIS	12,600	0	12,600	177,200	72	10.00
11.00	90.00	CLINIC	-7,374	-7,374	0	177,200	0	11.00
12.00	91.00	EMERGENCY	365,000	300,000	65,000	177,200	578	12.00
13.00	65.01	SLEEP LAB	110,000	110,000	0	215,700	0	13.00
14.00	60.00	LABORATORY	34,000	25,000	9,000	177,200	95	14.00
15.00	91.02	DIABETES CENTER	5,000	0	5,000	177,200	51	15.00
200.00			6,125,441	5,934,259	191,182		1,321	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	25,338	1,267	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	3,067	153	0	0	0	6.00
7.00	65.00	RESPIRATORY THERAPY	12,523	626	0	0	0	7.00
8.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	8.00
9.00	70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	9.00
10.00	74.00	RENAL DIALYSIS	6,134	307	0	0	0	10.00
11.00	90.00	CLINIC	0	0	0	0	0	11.00
12.00	91.00	EMERGENCY	49,241	2,462	0	0	0	12.00
13.00	65.01	SLEEP LAB	0	0	0	0	0	13.00
14.00	60.00	LABORATORY	8,093	405	0	0	0	14.00
15.00	91.02	DIABETES CENTER	4,345	217	0	0	0	15.00
200.00			108,741	5,437	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment		
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	3,066,661		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	1,204,717		2.00
3.00	31.00	INTENSIVE CARE UNIT	0	25,338	50,912	50,912		3.00
4.00	40.00	SUBPROVIDER - IPF	0	0	0	41,800		4.00
5.00	41.00	SUBPROVIDER - IRF	0	0	0	102,655		5.00
6.00	50.00	OPERATING ROOM	0	3,067	1,933	11,933		6.00
7.00	65.00	RESPIRATORY THERAPY	0	12,523	5,809	75,809		7.00
8.00	69.00	ELECTROCARDIOLOGY	0	0	0	160,000		8.00
9.00	70.00	ELECTROENCEPHALOGRAPHY	0	0	0	850,800		9.00
10.00	74.00	RENAL DIALYSIS	0	6,134	6,466	6,466		10.00
11.00	90.00	CLINIC	0	0	0	-7,374		11.00
12.00	91.00	EMERGENCY	0	49,241	15,759	315,759		12.00
13.00	65.01	SLEEP LAB	0	0	0	110,000		13.00
14.00	60.00	LABORATORY	0	8,093	907	25,907		14.00
15.00	91.02	DIABETES CENTER	0	4,345	655	655		15.00
200.00			0	108,741	82,441	6,016,700		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part I Date/Time Prepared: 2/27/2017 8:38 am

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	19,259,150	19,259,150				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	15,284,627		15,284,627			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	34,581,946	71,364	4,554	34,657,864		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	48,561,890	4,426,667	7,097,886	4,745,122	64,831,565	5.00
7.00	00700	OPERATION OF PLANT	8,779,453	236,962	56,245	842,568	9,915,228	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	138,084	81,509	0	28,860	248,453	8.00
9.00	00900	HOUSEKEEPING	3,629,592	202,075	46,371	687,684	4,565,722	9.00
10.00	01000	DIETARY	1,109,507	803,104	12,263	144,526	2,069,400	10.00
11.00	01100	CAFETERIA	1,428,117	0	39,350	488,883	1,956,350	11.00
13.00	01300	NURSING ADMINISTRATION	4,051,749	101,656	54,854	1,174,562	5,382,821	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	910,804	648,039	218,724	185,584	1,963,151	14.00
15.00	01500	PHARMACY	5,121,136	267,501	0	898,270	6,286,907	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,181,503	37,856	8,043	637,417	4,864,819	16.00
17.00	01700	SOCIAL SERVICE	367,664	0	0	107,609	475,273	17.00
23.00	02300	PARAMED ED PRGM	466,294	29,620	44,838	86,705	627,457	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	26,392,547	4,165,175	508,852	6,971,167	38,037,741	30.00
31.00	03100	INTENSIVE CARE UNIT	6,498,637	600,110	231,137	1,635,326	8,965,210	31.00
40.00	04000	SUBPROVIDER - IPF	2,291,697	391,602	21,162	561,991	3,266,452	40.00
41.00	04100	SUBPROVIDER - IRF	4,282,010	712,865	24,184	1,095,397	6,114,456	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	2,470,541	1,609,141	162,710	490,435	4,732,827	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	19,721,876	1,940,513	1,992,723	2,966,499	26,621,611	50.00
51.00	05100	RECOVERY ROOM	1,381,948	153,297	34,476	375,750	1,945,471	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,248,208	0	297,410	1,082,180	5,627,798	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,499,963	866,480	2,215,055	2,291,397	20,872,895	54.00
54.01	05401	ULTRASOUND	1,325,450	106,110	182,341	329,798	1,943,699	54.01
57.00	05700	CT SCAN	2,019,607	95,188	429,889	330,902	2,875,586	57.00
58.00	05800	MRI	1,211,985	122,722	280,980	186,096	1,801,783	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	9,523,580	21,172	48,723	1,112,293	10,705,768	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	1,873,989	0	5,570	77,574	1,957,133	63.00
65.00	06500	RESPIRATORY THERAPY	1,944,883	69,456	55,121	463,803	2,533,263	65.00
65.01	06501	SLEEP LAB	366,329	0	28,889	59,039	454,257	65.01
66.00	06600	PHYSICAL THERAPY	1,625,973	8,801	26,125	368,788	2,029,687	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,612,428	0	12,260	648,144	3,272,832	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,363,820	51,464	79,994	367,366	1,862,644	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	243,016	36,760	9,059	66,288	355,123	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	14,514,547	0	0	0	14,514,547	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	19,086,994	0	0	0	19,086,994	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,451,256	0	588,921	0	12,040,177	73.00
74.00	07400	RENAL DIALYSIS	596,221	102,363	33,107	127,757	859,448	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	599,817	0	2,793	136,818	739,428	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	8,507,623	1,127,230	426,393	2,114,740	12,175,986	91.00
91.01	09101	OP MENTAL HEALTH	490,657	108,407	1,819	139,479	740,362	91.01
91.02	09102	DIABETES CENTER	265,652	0	474	75,387	341,513	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					0	92.00
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	3,218,703	0	1,332	551,392	3,771,427	101.00
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part I Date/Time Prepared: 2/27/2017 8:38 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)	313,501,473	19,195,209	15,284,627	34,653,596	313,433,264	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	14,582	63,941	0	4,268	82,791	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)	313,516,055	19,259,150	15,284,627	34,657,864	313,516,055	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part I | Date/Time Prepared: 2/27/2017 8:38 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	64,831,565					5.00
7.00	00700	OPERATION OF PLANT	2,584,880	12,500,108				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	64,771	70,150	383,374			8.00
9.00	00900	HOUSEKEEPING	1,190,275	173,914	0	5,929,911		9.00
10.00	01000	DIETARY	539,488	691,185	0	334,420	3,634,493	10.00
11.00	01100	CAFETERIA	510,017	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	1,403,291	87,490	0	42,331	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	511,790	557,730	1,162	269,850	0	14.00
15.00	01500	PHARMACY	1,638,984	230,223	0	111,390	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,268,249	32,580	0	15,764	0	16.00
17.00	01700	SOCIAL SERVICE	123,903	0	0	0	0	17.00
23.00	02300	PARAMED ED PRGM	163,577	25,492	16,425	12,334	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,916,378	3,584,728	149,901	1,734,419	2,196,466	30.00
31.00	03100	INTENSIVE CARE UNIT	2,337,212	516,480	24,005	249,891	639,877	31.00
40.00	04000	SUBPROVIDER - IPF	851,558	337,029	1,250	163,067	234,665	40.00
41.00	04100	SUBPROVIDER - IRF	1,594,026	613,522	5,642	296,844	563,485	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	1,233,839	1,384,896	0	670,062	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	6,940,201	1,670,088	63,102	808,048	0	50.00
51.00	05100	RECOVERY ROOM	507,180	131,934	3,461	63,834	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,467,156	0	19,387	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,441,522	745,729	26,476	360,810	0	54.00
54.01	05401	ULTRASOUND	506,718	91,322	1,892	44,185	0	54.01
57.00	05700	CT SCAN	749,660	81,923	1,892	39,637	0	57.00
58.00	05800	MRI	469,721	105,620	3,630	51,103	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	2,790,972	18,222	0	8,816	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	510,221	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	660,417	59,776	0	28,922	0	65.00
65.01	06501	SLEEP LAB	118,424	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	529,135	7,575	0	3,665	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	853,221	0	9,826	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	485,588	44,292	341	21,430	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	92,580	31,637	0	15,307	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,783,913	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,975,941	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,138,850	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	224,056	88,098	0	42,625	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	192,767	0	166	0	0	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	3,174,255	970,142	54,816	469,389	0	91.00
91.01	09101	OP MENTAL HEALTH	193,011	93,300	0	45,142	0	91.01
91.02	09102	DIABETES CENTER	89,032	0	0	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	983,203	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	64,809,982	12,445,077	383,374	5,903,285	3,634,493	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	21,583	55,031	0	26,626	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part I Date/Time Prepared: 2/27/2017 8:38 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	201.00
202.00	TOTAL (sum lines 118-201)	64,831,565	12,500,108	383,374	5,929,911	3,634,493	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part I | Date/Time Prepared: 2/27/2017 8:38 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	2,466,367					11.00
13.00	01300	NURSING ADMINISTRATION	112,386	7,028,319				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	33,973	0	3,337,656			14.00
15.00	01500	PHARMACY	58,948	0	34,250	8,360,702		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	74,373	0	1,980	0	6,257,765	16.00
17.00	01700	SOCIAL SERVICE	11,018	0	0	0	0	17.00
23.00	02300	PARAMED ED PRGM	46,754	0	21,999	35,179	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	630,136	4,261,289	220,978	9,504	2,476,507	30.00
31.00	03100	INTENSIVE CARE UNIT	125,608	849,437	62,814	17,262	762,299	31.00
40.00	04000	SUBPROVIDER - IPF	53,071	0	4,292	0	198,937	40.00
41.00	04100	SUBPROVIDER - IRF	96,226	650,739	0	0	193,469	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	39,611	267,843	26,984	0	267,448	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	265,008	0	365,847	0	0	50.00
51.00	05100	RECOVERY ROOM	25,158	0	4,799	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	88,403	597,888	41,654	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	212,910	0	103,942	22,168	0	54.00
54.01	05401	ULTRASOUND	24,607	0	13,283	0	0	54.01
57.00	05700	CT SCAN	26,995	0	33,967	0	0	57.00
58.00	05800	MRI	12,671	0	16,593	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	121,385	0	419,272	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	6,978	0	22,916	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	44,257	0	24,048	0	0	65.00
65.01	06501	SLEEP LAB	6,611	0	1,996	0	0	65.01
66.00	06600	PHYSICAL THERAPY	28,648	0	1,098	0	576,066	66.00
67.00	06700	OCCUPATIONAL THERAPY	53,071	0	6,994	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	32,137	0	4,514	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	6,795	0	890	0	133,804	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	1,779,997	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	8,275,426	0	73.00
74.00	07400	RENAL DIALYSIS	7,713	52,158	12,721	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	9,329	0	4,664	0	25,249	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	188,449	0	94,080	0	1,623,986	91.00
91.01	09101	OP MENTAL HEALTH	13,589	0	1,356	0	0	91.01
91.02	09102	DIABETES CENTER	8,264	55,884	742	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	293,081	8,986	1,163	0	101.00
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	2,465,082	7,028,319	3,337,656	8,360,702	6,257,765	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,285	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part I Date/Time Prepared: 2/27/2017 8:38 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	201.00
202.00	TOTAL (sum lines 118-201)	2,466,367	7,028,319	3,337,656	8,360,702	6,257,765	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part I | Date/Time Prepared: 2/27/2017 8:38 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	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	610,194					17.00
23.00	02300	PARAMED ED PRGM	0	949,217				23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	530,020	0	63,748,067	0	63,748,067	30.00
31.00	03100	INTENSIVE CARE UNIT	32,503	47,246	14,629,844	0	14,629,844	31.00
40.00	04000	SUBPROVIDER - IPF	0	30,663	5,140,984	0	5,140,984	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	10,128,409	0	10,128,409	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	8,623,510	0	8,623,510	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	36,733,905	0	36,733,905	50.00
51.00	05100	RECOVERY ROOM	0	0	2,681,837	0	2,681,837	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	27,534	7,869,820	0	7,869,820	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	27,786,452	0	27,786,452	54.00
54.01	05401	ULTRASOUND	0	0	2,625,706	0	2,625,706	54.01
57.00	05700	CT SCAN	0	0	3,809,660	0	3,809,660	57.00
58.00	05800	MRI	0	0	2,461,121	0	2,461,121	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	14,064,435	0	14,064,435	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	2,497,248	0	2,497,248	63.00
65.00	06500	RESPIRATORY THERAPY	0	28,785	3,379,468	0	3,379,468	65.00
65.01	06501	SLEEP LAB	0	0	581,288	0	581,288	65.01
66.00	06600	PHYSICAL THERAPY	0	0	3,175,874	0	3,175,874	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	4,195,944	0	4,195,944	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	23,154	2,474,100	0	2,474,100	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	636,136	0	636,136	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	20,078,457	0	20,078,457	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	24,062,935	0	24,062,935	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	23,454,453	0	23,454,453	73.00
74.00	07400	RENAL DIALYSIS	0	0	1,286,819	0	1,286,819	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	7,584	0	979,187	0	979,187	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	40,087	791,835	19,583,025	0	19,583,025	91.00
91.01	09101	OP MENTAL HEALTH	0	0	1,086,760	0	1,086,760	91.01
91.02	09102	DIABETES CENTER	0	0	495,435	0	495,435	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	5,057,860	0	5,057,860	101.00
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	610,194	949,217	313,328,739	0	313,328,739	118.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part I Date/Time Prepared: 2/27/2017 8:38 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	187,316	0	187,316	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments		0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	610,194	949,217	313,516,055	0	313,516,055	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part II | Date/Time Prepared: 2/27/2017 8:38 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	71,364	4,554	75,918	75,918	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	4,426,667	7,097,886	11,524,553	10,392	5.00
7.00	00700	OPERATION OF PLANT	0	236,962	56,245	293,207	1,845	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	81,509	0	81,509	63	8.00
9.00	00900	HOUSEKEEPING	0	202,075	46,371	248,446	1,506	9.00
10.00	01000	DIETARY	0	803,104	12,263	815,367	317	10.00
11.00	01100	CAFETERIA	0	0	39,350	39,350	1,071	11.00
13.00	01300	NURSING ADMINISTRATION	0	101,656	54,854	156,510	2,572	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	648,039	218,724	866,763	406	14.00
15.00	01500	PHARMACY	0	267,501	0	267,501	1,967	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	37,856	8,043	45,899	1,396	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	236	17.00
23.00	02300	PARAMED ED PRGM	0	29,620	44,838	74,458	190	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	4,165,175	508,852	4,674,027	15,282	30.00
31.00	03100	INTENSIVE CARE UNIT	0	600,110	231,137	831,247	3,582	31.00
40.00	04000	SUBPROVIDER - IPF	0	391,602	21,162	412,764	1,231	40.00
41.00	04100	SUBPROVIDER - IRF	0	712,865	24,184	737,049	2,399	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	1,609,141	162,710	1,771,851	1,074	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	1,940,513	1,992,723	3,933,236	6,497	50.00
51.00	05100	RECOVERY ROOM	0	153,297	34,476	187,773	823	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	297,410	297,410	2,370	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	866,480	2,215,055	3,081,535	5,018	54.00
54.01	05401	ULTRASOUND	0	106,110	182,341	288,451	722	54.01
57.00	05700	CT SCAN	0	95,188	429,889	525,077	725	57.00
58.00	05800	MRI	0	122,722	280,980	403,702	408	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	21,172	48,723	69,895	2,436	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	5,570	5,570	170	63.00
65.00	06500	RESPIRATORY THERAPY	0	69,456	55,121	124,577	1,016	65.00
65.01	06501	SLEEP LAB	0	0	28,889	28,889	129	65.01
66.00	06600	PHYSICAL THERAPY	0	8,801	26,125	34,926	808	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	12,260	12,260	1,419	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	51,464	79,994	131,458	805	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	36,760	9,059	45,819	145	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	588,921	588,921	0	73.00
74.00	07400	RENAL DIALYSIS	0	102,363	33,107	135,470	280	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	2,793	2,793	300	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	1,127,230	426,393	1,553,623	4,631	91.00
91.01	09101	OP MENTAL HEALTH	0	108,407	1,819	110,226	305	91.01
91.02	09102	DIABETES CENTER	0	0	474	474	165	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	1,332	1,332	1,208	101.00
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	19,195,209	15,284,627	34,479,836	75,909	118.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part II Date/Time Prepared: 2/27/2017 8:38 am

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	63,941	0	63,941	9	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	19,259,150	15,284,627	34,543,777	75,918	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part II | Date/Time Prepared: 2/27/2017 8:38 am

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	11,534,945					5.00
7.00	00700	OPERATION OF PLANT	459,908	754,960				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	11,524	4,237	97,333			8.00
9.00	00900	HOUSEKEEPING	211,776	10,504	0	472,232		9.00
10.00	01000	DIETARY	95,987	41,745	0	26,632	980,048	10.00
11.00	01100	CAFETERIA	90,743	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	249,677	5,284	0	3,371	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	91,059	33,685	295	21,490	0	14.00
15.00	01500	PHARMACY	291,612	13,905	0	8,871	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	225,650	1,968	0	1,255	0	16.00
17.00	01700	SOCIAL SERVICE	22,045	0	0	0	0	17.00
23.00	02300	PARAMED ED PRGM	29,104	1,540	4,170	982	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,764,305	216,503	38,057	138,122	592,281	30.00
31.00	03100	INTENSIVE CARE UNIT	415,842	31,193	6,095	19,900	172,544	31.00
40.00	04000	SUBPROVIDER - IPF	151,511	20,355	317	12,986	63,278	40.00
41.00	04100	SUBPROVIDER - IRF	283,613	37,054	1,433	23,639	151,945	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	219,527	83,643	0	53,361	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	1,234,817	100,867	16,021	64,349	0	50.00
51.00	05100	RECOVERY ROOM	90,239	7,968	879	5,083	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	261,040	0	4,922	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	968,168	45,039	6,722	28,733	0	54.00
54.01	05401	ULTRASOUND	90,157	5,516	480	3,519	0	54.01
57.00	05700	CT SCAN	133,381	4,948	480	3,157	0	57.00
58.00	05800	MRI	83,574	6,379	922	4,070	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	496,576	1,101	0	702	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	90,780	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	117,503	3,610	0	2,303	0	65.00
65.01	06501	SLEEP LAB	21,070	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	94,145	457	0	292	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	151,807	0	2,495	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	86,397	2,675	86	1,707	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	16,472	1,911	0	1,219	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	673,243	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	885,331	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	558,472	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	39,865	5,321	0	3,394	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	34,298	0	42	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	564,771	58,593	13,917	37,380	0	91.00
91.01	09101	OP MENTAL HEALTH	34,341	5,635	0	3,595	0	91.01
91.02	09102	DIABETES CENTER	15,841	0	0	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	174,934	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	11,531,105	751,636	97,333	470,112	980,048	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,840	3,324	0	2,120	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part II Date/Time Prepared: 2/27/2017 8:38 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	201.00
202.00	TOTAL (sum lines 118-201)	11,534,945	754,960	97,333	472,232	980,048	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part II | Date/Time Prepared: 2/27/2017 8:38 am

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	131,164					11.00
13.00	01300	NURSING ADMINISTRATION	5,977	423,391				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,807	0	1,015,505			14.00
15.00	01500	PHARMACY	3,135	0	10,421	597,412		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,955	0	602	0	280,725	16.00
17.00	01700	SOCIAL SERVICE	586	0	0	0	0	17.00
23.00	02300	PARAMED ED PRGM	2,486	0	6,693	2,514	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	33,512	256,704	67,235	679	111,098	30.00
31.00	03100	INTENSIVE CARE UNIT	6,680	51,171	19,112	1,233	34,197	31.00
40.00	04000	SUBPROVIDER - IPF	2,822	0	1,306	0	8,924	40.00
41.00	04100	SUBPROVIDER - IRF	5,117	39,201	0	0	8,679	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	2,107	16,135	8,210	0	11,998	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	14,093	0	111,312	0	0	50.00
51.00	05100	RECOVERY ROOM	1,338	0	1,460	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,701	36,017	12,673	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	11,323	0	31,625	1,584	0	54.00
54.01	05401	ULTRASOUND	1,309	0	4,041	0	0	54.01
57.00	05700	CT SCAN	1,436	0	10,335	0	0	57.00
58.00	05800	MRI	674	0	5,049	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	6,455	0	127,567	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	371	0	6,972	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	2,354	0	7,317	0	0	65.00
65.01	06501	SLEEP LAB	352	0	607	0	0	65.01
66.00	06600	PHYSICAL THERAPY	1,524	0	334	0	25,842	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,822	0	2,128	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,709	0	1,373	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	361	0	271	0	6,002	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	541,575	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	591,319	0	73.00
74.00	07400	RENAL DIALYSIS	410	3,142	3,870	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	496	0	1,419	0	1,133	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	10,022	0	28,625	0	72,852	91.00
91.01	09101	OP MENTAL HEALTH	723	0	413	0	0	91.01
91.02	09102	DIABETES CENTER	439	3,366	226	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	17,655	2,734	83	0	101.00
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	131,096	423,391	1,015,505	597,412	280,725	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	68	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part II Date/Time Prepared: 2/27/2017 8:38 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	201.00
202.00	TOTAL (sum lines 118-201)	131,164	423,391	1,015,505	597,412	280,725	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part II | Date/Time Prepared: 2/27/2017 8:38 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	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	22,867					17.00
23.00	02300	PARAMED ED PRGM	0	122,137				23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	19,863		7,927,668	0	7,927,668	30.00
31.00	03100	INTENSIVE CARE UNIT	1,218		1,594,014	0	1,594,014	31.00
40.00	04000	SUBPROVIDER - IPF	0		675,494	0	675,494	40.00
41.00	04100	SUBPROVIDER - IRF	0		1,290,129	0	1,290,129	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	42.00
43.00	04300	NURSERY	0		2,167,906	0	2,167,906	43.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
45.00	04500	NURSING FACILITY	0		0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0		5,481,192	0	5,481,192	50.00
51.00	05100	RECOVERY ROOM	0		295,563	0	295,563	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		619,133	0	619,133	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		4,179,747	0	4,179,747	54.00
54.01	05401	ULTRASOUND	0		394,195	0	394,195	54.01
57.00	05700	CT SCAN	0		679,539	0	679,539	57.00
58.00	05800	MRI	0		504,778	0	504,778	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	0		704,732	0	704,732	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0		103,863	0	103,863	63.00
65.00	06500	RESPIRATORY THERAPY	0		258,680	0	258,680	65.00
65.01	06501	SLEEP LAB	0		51,047	0	51,047	65.01
66.00	06600	PHYSICAL THERAPY	0		158,328	0	158,328	66.00
67.00	06700	OCCUPATIONAL THERAPY	0		172,931	0	172,931	67.00
68.00	06800	SPEECH PATHOLOGY	0		0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0		226,210	0	226,210	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		72,200	0	72,200	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		1,214,818	0	1,214,818	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		885,331	0	885,331	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		1,738,712	0	1,738,712	73.00
74.00	07400	RENAL DIALYSIS	0		191,752	0	191,752	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000	CLINIC	284		40,765	0	40,765	90.00
90.01	09001	HOMER GLEN LAB	0		0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0		0	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0		0	0	0	90.03
91.00	09100	EMERGENCY	1,502		2,345,916	0	2,345,916	91.00
91.01	09101	OP MENTAL HEALTH	0		155,238	0	155,238	91.01
91.02	09102	DIABETES CENTER	0		20,511	0	20,511	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0		0	0	0	94.00
99.00	09900	CMHC	0		0	0	0	99.00
99.10	09910	CORF	0		0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0		197,946	0	197,946	101.00
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0		0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0		0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0		0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	22,867	0	34,348,338	0	34,348,338	118.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B Part II Date/Time Prepared: 2/27/2017 8:38 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		73,302	0	73,302	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		0	0	0	192.00
200.00		Cross Foot Adjustments		122,137	122,137	0	122,137	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	22,867	122,137	34,543,777	0	34,543,777	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B-1 | Date/Time Prepared: 2/27/2017 8:38 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	544,870					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		13,686,362				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	2,019	4,078	118,414,697			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	125,237	6,355,683	16,212,552	-64,831,565	248,684,490	5.00
7.00	00700	OPERATION OF PLANT	6,704	50,364	2,878,783	0	9,915,228	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,306	0	98,606	0	248,453	8.00
9.00	00900	HOUSEKEEPING	5,717	41,522	2,349,593	0	4,565,722	9.00
10.00	01000	DIETARY	22,721	10,981	493,800	0	2,069,400	10.00
11.00	01100	CAFETERIA	0	35,235	1,670,354	0	1,956,350	11.00
13.00	01300	NURSING ADMINISTRATION	2,876	49,118	4,013,099	0	5,382,821	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	18,334	195,853	634,079	0	1,963,151	14.00
15.00	01500	PHARMACY	7,568	0	3,069,099	0	6,286,907	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,071	7,202	2,177,849	0	4,864,819	16.00
17.00	01700	SOCIAL SERVICE	0	0	367,664	0	475,273	17.00
23.00	02300	PARAMED ED PRGM	838	40,149	296,244	0	627,457	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	117,839	455,643	23,818,188	0	38,037,741	30.00
31.00	03100	INTENSIVE CARE UNIT	16,978	206,968	5,587,382	0	8,965,210	31.00
40.00	04000	SUBPROVIDER - IPF	11,079	18,949	1,920,143	0	3,266,452	40.00
41.00	04100	SUBPROVIDER - IRF	20,168	21,655	3,742,618	0	6,114,456	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	45,525	145,696	1,675,657	0	4,732,827	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	54,900	1,784,350	10,135,569	0	26,621,611	50.00
51.00	05100	RECOVERY ROOM	4,337	30,871	1,283,817	0	1,945,471	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	266,311	3,697,460	0	5,627,798	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	24,514	1,983,434	7,828,965	0	20,872,895	54.00
54.01	05401	ULTRASOUND	3,002	163,274	1,126,812	0	1,943,699	54.01
57.00	05700	CT SCAN	2,693	384,937	1,130,587	0	2,875,586	57.00
58.00	05800	MRI	3,472	251,599	635,829	0	1,801,783	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	599	43,628	3,800,345	0	10,705,768	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	4,988	265,045	0	1,957,133	63.00
65.00	06500	RESPIRATORY THERAPY	1,965	49,357	1,584,666	0	2,533,263	65.00
65.01	06501	SLEEP LAB	0	25,868	201,717	0	454,257	65.01
66.00	06600	PHYSICAL THERAPY	249	23,393	1,260,029	0	2,029,687	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	10,978	2,214,498	0	3,272,832	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,456	71,629	1,255,172	0	1,862,644	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,040	8,112	226,485	0	355,123	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	14,514,547	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	19,086,994	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	527,339	0	0	12,040,177	73.00
74.00	07400	RENAL DIALYSIS	2,896	29,645	436,506	0	859,448	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	2,501	467,464	0	739,428	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	31,891	381,806	7,225,383	0	12,175,986	91.00
91.01	09101	OP MENTAL HEALTH	3,067	1,629	476,554	0	740,362	91.01
91.02	09102	DIABETES CENTER	0	424	257,573	0	341,513	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	1,193	1,883,929	0	3,771,427	101.00
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B-1 | Date/Time Prepared: 2/27/2017 8:38 am

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
118.00		SUBTOTALS (SUM OF LINES 1-117)	543,061	13,686,362	118,400,115	-64,831,565	248,601,699	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,809	0	14,582	0	82,791	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)	19,259,150	15,284,627	34,657,864		64,831,565	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	35.346321	1.116778	0.292682		0.260698	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			75,918		11,534,945	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000641		0.046384	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B-1 | Date/Time Prepared: 2/27/2017 8:38 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	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	410,910					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,306	2,335,798				8.00
9.00	00900	HOUSEKEEPING	5,717	0	402,887			9.00
10.00	01000	DIETARY	22,721	0	22,721	258,201		10.00
11.00	01100	CAFETERIA	0	0	0	0	134,306	11.00
13.00	01300	NURSING ADMINISTRATION	2,876	0	2,876	0	6,120	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	18,334	7,082	18,334	0	1,850	14.00
15.00	01500	PHARMACY	7,568	0	7,568	0	3,210	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,071	0	1,071	0	4,050	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	600	17.00
23.00	02300	PARAMED ED PRGM	838	100,074	838	0	2,546	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	117,839	913,294	117,839	156,041	34,314	30.00
31.00	03100	INTENSIVE CARE UNIT	16,978	146,258	16,978	45,458	6,840	31.00
40.00	04000	SUBPROVIDER - IPF	11,079	7,617	11,079	16,671	2,890	40.00
41.00	04100	SUBPROVIDER - IRF	20,168	34,378	20,168	40,031	5,240	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	45,525	0	45,525	0	2,157	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	54,900	384,465	54,900	0	14,431	50.00
51.00	05100	RECOVERY ROOM	4,337	21,089	4,337	0	1,370	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	118,120	0	0	4,814	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	24,514	161,314	24,514	0	11,594	54.00
54.01	05401	ULTRASOUND	3,002	11,529	3,002	0	1,340	54.01
57.00	05700	CT SCAN	2,693	11,529	2,693	0	1,470	57.00
58.00	05800	MRI	3,472	22,116	3,472	0	690	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	599	0	599	0	6,610	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	380	63.00
65.00	06500	RESPIRATORY THERAPY	1,965	0	1,965	0	2,410	65.00
65.01	06501	SLEEP LAB	0	0	0	0	360	65.01
66.00	06600	PHYSICAL THERAPY	249	0	249	0	1,560	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	59,869	0	0	2,890	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,456	2,075	1,456	0	1,750	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,040	0	1,040	0	370	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	2,896	0	2,896	0	420	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	1,010	0	0	508	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	31,891	333,979	31,891	0	10,262	91.00
91.01	09101	OP MENTAL HEALTH	3,067	0	3,067	0	740	91.01
91.02	09102	DIABETES CENTER	0	0	0	0	450	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	409,101	2,335,798	401,078	258,201	134,236	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,809	0	1,809	0	70	190.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B-1 | Date/Time Prepared: 2/27/2017 8:38 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	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)	12,500,108	383,374	5,929,911	3,634,493	2,466,367	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	30.420550	0.164130	14.718546	14.076216	18.363789	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	754,960	97,333	472,232	980,048	131,164	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.837288	0.041670	1.172120	3.795679	0.976606	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B-1 | Date/Time Prepared: 2/27/2017 8:38 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	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION	1,177,171					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	27,405,457				14.00
15.00	01500	PHARMACY	0	281,223	11,569,260			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	16,257	0	38,911		16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	2,816	17.00
23.00	02300	PARAMED ED PRGM	0	180,635	48,680	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	713,722	1,814,452	13,152	15,399	2,446	30.00
31.00	03100	INTENSIVE CARE UNIT	142,272	515,768	23,887	4,740	150	31.00
40.00	04000	SUBPROVIDER - IPF	0	35,238	0	1,237	0	40.00
41.00	04100	SUBPROVIDER - IRF	108,992	0	0	1,203	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	44,861	221,563	0	1,663	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	3,003,969	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	39,408	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	100,140	342,017	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	853,466	30,676	0	0	54.00
54.01	05401	ULTRASOUND	0	109,064	0	0	0	54.01
57.00	05700	CT SCAN	0	278,906	0	0	0	57.00
58.00	05800	MRI	0	136,245	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	3,442,639	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	188,161	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	197,461	0	0	0	65.00
65.01	06501	SLEEP LAB	0	16,386	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	9,017	0	3,582	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	57,428	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	37,063	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	7,304	0	832	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	14,615,530	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	11,451,256	0	0	73.00
74.00	07400	RENAL DIALYSIS	8,736	104,452	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	38,297	0	157	35	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	772,492	0	10,098	185	91.00
91.01	09101	OP MENTAL HEALTH	0	11,134	0	0	0	91.01
91.02	09102	DIABETES CENTER	9,360	6,095	0	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	49,088	73,787	1,609	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,177,171	27,405,457	11,569,260	38,911	2,816	118.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B-1 | Date/Time Prepared: 2/27/2017 8:38 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	
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	7,028,319	3,337,656	8,360,702	6,257,765	610,194	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	5.970517	0.121788	0.722665	160.822518	216.688210	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	423,391	1,015,505	597,412	280,725	22,867	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.359668	0.037055	0.051638	7.214541	8.120384	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B-1 | Date/Time Prepared: 2/27/2017 8:38 am

		Cost Center Description	PARAMED ED PRGM (ASSIGNED TIME)	
			23.00	
		GENERAL SERVICE COST CENTERS		
1.00	00100	CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT		4.00
5.00	00500	ADMINISTRATIVE & GENERAL		5.00
7.00	00700	OPERATION OF PLANT		7.00
8.00	00800	LAUNDRY & LINEN SERVICE		8.00
9.00	00900	HOUSEKEEPING		9.00
10.00	01000	DIETARY		10.00
11.00	01100	CAFETERIA		11.00
13.00	01300	NURSING ADMINISTRATION		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY		14.00
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE		17.00
23.00	02300	PARAMED ED PRGM	12,135	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	604	31.00
40.00	04000	SUBPROVIDER - IPF	392	40.00
41.00	04100	SUBPROVIDER - IRF	0	41.00
42.00	04200	SUBPROVIDER	0	42.00
43.00	04300	NURSERY	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	44.00
45.00	04500	NURSING FACILITY	0	45.00
		ANCILLARY SERVICE COST CENTERS		
50.00	05000	OPERATING ROOM	0	50.00
51.00	05100	RECOVERY ROOM	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	352	52.00
53.00	05300	ANESTHESIOLOGY	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54.00
54.01	05401	ULTRASOUND	0	54.01
57.00	05700	CT SCAN	0	57.00
58.00	05800	MRI	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	59.00
60.00	06000	LABORATORY	0	60.00
60.01	06001	BLOOD LABORATORY	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	63.00
65.00	06500	RESPIRATORY THERAPY	368	65.00
65.01	06501	SLEEP LAB	0	65.01
66.00	06600	PHYSICAL THERAPY	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	68.00
69.00	06900	ELECTROCARDIOLOGY	296	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73.00
74.00	07400	RENAL DIALYSIS	0	74.00
		OUTPATIENT SERVICE COST CENTERS		
88.00	08800	RURAL HEALTH CLINIC	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	89.00
90.00	09000	CLINIC	0	90.00
90.01	09001	HOMER GLEN LAB	0	90.01
90.02	09002	HOMER GLEN FEC	0	90.02
90.03	09003	WOMEN'S HEALTH	0	90.03
91.00	09100	EMERGENCY	10,123	91.00
91.01	09101	OP MENTAL HEALTH	0	91.01
91.02	09102	DIABETES CENTER	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART		92.00
		OTHER REIMBURSABLE COST CENTERS		
94.00	09400	HOME PROGRAM DIALYSIS	0	94.00
99.00	09900	CMHC	0	99.00
99.10	09910	CORF	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	101.00
		SPECIAL PURPOSE COST CENTERS		
109.00	10900	PANCREAS ACQUISITION	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	110.00
111.00	11100	ISLET ACQUISITION	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	12,135	118.00
		NONREIMBURSABLE COST CENTERS		
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	190.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet B-1 | Date/Time Prepared: 2/27/2017 8:38 am

		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)	949,217		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	78.221426		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	122,137		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	10.064854		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet C Part I Date/Time Prepared: 2/27/2017 8:38 am

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	63,748,067		63,748,067	0	63,748,067	30.00
31.00	03100	INTENSIVE CARE UNIT	14,629,844		14,629,844	50,912	14,680,756	31.00
40.00	04000	SUBPROVIDER - IPF	5,140,984		5,140,984	0	5,140,984	40.00
41.00	04100	SUBPROVIDER - IRF	10,128,409		10,128,409	0	10,128,409	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	42.00
43.00	04300	NURSERY	8,623,510		8,623,510	0	8,623,510	43.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
45.00	04500	NURSING FACILITY	0		0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	36,733,905		36,733,905	1,933	36,735,838	50.00
51.00	05100	RECOVERY ROOM	2,681,837		2,681,837	0	2,681,837	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,869,820		7,869,820	0	7,869,820	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	27,786,452		27,786,452	0	27,786,452	54.00
54.01	05401	ULTRASOUND	2,625,706		2,625,706	0	2,625,706	54.01
57.00	05700	CT SCAN	3,809,660		3,809,660	0	3,809,660	57.00
58.00	05800	MRI	2,461,121		2,461,121	0	2,461,121	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	14,064,435		14,064,435	907	14,065,342	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,497,248		2,497,248	0	2,497,248	63.00
65.00	06500	RESPIRATORY THERAPY	3,379,468	0	3,379,468	5,809	3,385,277	65.00
65.01	06501	SLEEP LAB	581,288	0	581,288	0	581,288	65.01
66.00	06600	PHYSICAL THERAPY	3,175,874	0	3,175,874	0	3,175,874	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,195,944	0	4,195,944	0	4,195,944	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,474,100		2,474,100	0	2,474,100	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	636,136		636,136	0	636,136	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	20,078,457		20,078,457	0	20,078,457	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	24,062,935		24,062,935	0	24,062,935	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	23,454,453		23,454,453	0	23,454,453	73.00
74.00	07400	RENAL DIALYSIS	1,286,819		1,286,819	6,466	1,293,285	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000	CLINIC	979,187		979,187	0	979,187	90.00
90.01	09001	HOMER GLEN LAB	0		0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0		0	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0		0	0	0	90.03
91.00	09100	EMERGENCY	19,583,025		19,583,025	15,759	19,598,784	91.00
91.01	09101	OP MENTAL HEALTH	1,086,760		1,086,760	0	1,086,760	91.01
91.02	09102	DIABETES CENTER	495,435		495,435	655	496,090	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	8,359,406		8,359,406		8,359,406	92.00
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0		0	0	0	94.00
99.00	09900	CMHC	0		0		0	99.00
99.10	09910	CORF	0		0		0	99.10
101.00	10100	HOME HEALTH AGENCY	5,057,860		5,057,860		5,057,860	101.00
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0		0		0	109.00
110.00	11000	INTESTINAL ACQUISITION	0		0		0	110.00
111.00	11100	ISLET ACQUISITION	0		0		0	111.00
200.00		Subtotal (see instructions)	321,688,145	0	321,688,145	82,441	321,770,586	200.00
201.00		Less Observation Beds	8,359,406		8,359,406		8,359,406	201.00
202.00		Total (see instructions)	313,328,739	0	313,328,739	82,441	313,411,180	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet C Part I Date/Time Prepared: 2/27/2017 8:38 am

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		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	65,444,032		65,444,032			30.00
31.00	03100	INTENSIVE CARE UNIT	19,065,027		19,065,027			31.00
40.00	04000	SUBPROVIDER - IPF	6,991,757		6,991,757			40.00
41.00	04100	SUBPROVIDER - IRF	16,789,294		16,789,294			41.00
42.00	04200	SUBPROVIDER	0		0			42.00
43.00	04300	NURSERY	10,831,193		10,831,193			43.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
45.00	04500	NURSING FACILITY	0		0			45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	80,140,399	105,652,046	185,792,445	0.197715	0.000000	50.00
51.00	05100	RECOVERY ROOM	15,883,703	12,037,662	27,921,365	0.096050	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,083,574	926,102	10,009,676	0.786221	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	40,581,141	117,201,486	157,782,627	0.176106	0.000000	54.00
54.01	05401	ULTRASOUND	8,430,352	19,434,130	27,864,482	0.094231	0.000000	54.01
57.00	05700	CT SCAN	34,198,391	77,064,286	111,262,677	0.034240	0.000000	57.00
58.00	05800	MRI	9,709,662	21,689,562	31,399,224	0.078382	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	68,200,756	109,885,818	178,086,574	0.078975	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	6,812,591	2,800,145	9,612,736	0.259785	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	14,085,984	2,379,163	16,465,147	0.205250	0.000000	65.00
65.01	06501	SLEEP LAB	0	3,795,912	3,795,912	0.153135	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	9,248,898	395,419	9,644,317	0.329300	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,552,368	7,522,886	12,075,254	0.347483	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	11,928,172	9,925,978	21,854,150	0.113210	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	710,791	1,984,329	2,695,120	0.236033	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	26,959,023	11,451,679	38,410,702	0.522731	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	33,124,821	14,879,139	48,003,960	0.501270	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	49,407,448	22,457,577	71,865,025	0.326368	0.000000	73.00
74.00	07400	RENAL DIALYSIS	4,155,123	15,230	4,170,353	0.308564	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0			88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			89.00
90.00	09000	CLINIC	16,762	827,556	844,318	1.159737	0.000000	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0.000000	0.000000	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0.000000	0.000000	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0	0.000000	0.000000	90.03
91.00	09100	EMERGENCY	28,382,367	70,470,225	98,852,592	0.198103	0.000000	91.00
91.01	09101	OP MENTAL HEALTH	0	2,250,386	2,250,386	0.482922	0.000000	91.01
91.02	09102	DIABETES CENTER	71,522	338,816	410,338	1.207383	0.000000	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,298,461	8,785,135	10,083,596	0.829010	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0.000000	0.000000	94.00
99.00	09900	CMHC	0	0	0			99.00
99.10	09910	CORF	0	0	0			99.10
101.00	10100	HOME HEALTH AGENCY	0	6,334,138	6,334,138			101.00
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0			109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0			110.00
111.00	11100	ISLET ACQUISITION	0	0	0			111.00
200.00		Subtotal (see instructions)	576,103,612	630,504,805	1,206,608,417			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	576,103,612	630,504,805	1,206,608,417			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet C Part I Date/Time Prepared: 2/27/2017 8:38 am

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		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
41.00	04100	SUBPROVIDER - IRF			41.00
42.00	04200	SUBPROVIDER			42.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
45.00	04500	NURSING FACILITY			45.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.197725		50.00
51.00	05100	RECOVERY ROOM	0.096050		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.786221		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.176106		54.00
54.01	05401	ULTRASOUND	0.094231		54.01
57.00	05700	CT SCAN	0.034240		57.00
58.00	05800	MRI	0.078382		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.078980		60.00
60.01	06001	BLOOD LABORATORY	0.000000		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.259785		63.00
65.00	06500	RESPIRATORY THERAPY	0.205603		65.00
65.01	06501	SLEEP LAB	0.153135		65.01
66.00	06600	PHYSICAL THERAPY	0.329300		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.347483		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.113210		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.236033		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.522731		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.501270		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.326368		73.00
74.00	07400	RENAL DIALYSIS	0.310114		74.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC			88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER			89.00
90.00	09000	CLINIC	1.159737		90.00
90.01	09001	HOMER GLEN LAB	0.000000		90.01
90.02	09002	HOMER GLEN FEC	0.000000		90.02
90.03	09003	WOMEN'S HEALTH	0.000000		90.03
91.00	09100	EMERGENCY	0.198263		91.00
91.01	09101	OP MENTAL HEALTH	0.482922		91.01
91.02	09102	DIABETES CENTER	1.208979		91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.829010		92.00
		OTHER REIMBURSABLE COST CENTERS			
94.00	09400	HOME PROGRAM DIALYSIS	0.000000		94.00
99.00	09900	CMHC			99.00
99.10	09910	CORF			99.10
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
109.00	10900	PANCREAS ACQUISITION			109.00
110.00	11000	INTESTINAL ACQUISITION			110.00
111.00	11100	ISLET ACQUISITION			111.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet C Part I Date/Time Prepared: 2/27/2017 8:38 am

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		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	63,748,067		63,748,067	0	63,748,067	30.00
31.00	03100	INTENSIVE CARE UNIT	14,629,844		14,629,844	50,912	14,680,756	31.00
40.00	04000	SUBPROVIDER - IPF	5,140,984		5,140,984	0	5,140,984	40.00
41.00	04100	SUBPROVIDER - IRF	10,128,409		10,128,409	0	10,128,409	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	42.00
43.00	04300	NURSERY	8,623,510		8,623,510	0	8,623,510	43.00
44.00	04400	SKILLED NURSING FACILITY	0		0	0	0	44.00
45.00	04500	NURSING FACILITY	0		0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	36,733,905		36,733,905	1,933	36,735,838	50.00
51.00	05100	RECOVERY ROOM	2,681,837		2,681,837	0	2,681,837	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,869,820		7,869,820	0	7,869,820	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	27,786,452		27,786,452	0	27,786,452	54.00
54.01	05401	ULTRASOUND	2,625,706		2,625,706	0	2,625,706	54.01
57.00	05700	CT SCAN	3,809,660		3,809,660	0	3,809,660	57.00
58.00	05800	MRI	2,461,121		2,461,121	0	2,461,121	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	14,064,435		14,064,435	907	14,065,342	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,497,248		2,497,248	0	2,497,248	63.00
65.00	06500	RESPIRATORY THERAPY	3,379,468	0	3,379,468	5,809	3,385,277	65.00
65.01	06501	SLEEP LAB	581,288	0	581,288	0	581,288	65.01
66.00	06600	PHYSICAL THERAPY	3,175,874	0	3,175,874	0	3,175,874	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,195,944	0	4,195,944	0	4,195,944	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,474,100		2,474,100	0	2,474,100	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	636,136		636,136	0	636,136	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	20,078,457		20,078,457	0	20,078,457	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	24,062,935		24,062,935	0	24,062,935	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	23,454,453		23,454,453	0	23,454,453	73.00
74.00	07400	RENAL DIALYSIS	1,286,819		1,286,819	6,466	1,293,285	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000	CLINIC	979,187		979,187	0	979,187	90.00
90.01	09001	HOMER GLEN LAB	0		0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0		0	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0		0	0	0	90.03
91.00	09100	EMERGENCY	19,583,025		19,583,025	15,759	19,598,784	91.00
91.01	09101	OP MENTAL HEALTH	1,086,760		1,086,760	0	1,086,760	91.01
91.02	09102	DIABETES CENTER	495,435		495,435	655	496,090	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	8,359,406		8,359,406		8,359,406	92.00
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0		0	0	0	94.00
99.00	09900	CMHC	0		0		0	99.00
99.10	09910	CORF	0		0		0	99.10
101.00	10100	HOME HEALTH AGENCY	5,057,860		5,057,860		5,057,860	101.00
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0		0		0	109.00
110.00	11000	INTESTINAL ACQUISITION	0		0		0	110.00
111.00	11100	ISLET ACQUISITION	0		0		0	111.00
200.00		Subtotal (see instructions)	321,688,145	0	321,688,145	82,441	321,770,586	200.00
201.00		Less Observation Beds	8,359,406		8,359,406		8,359,406	201.00
202.00		Total (see instructions)	313,328,739	0	313,328,739	82,441	313,411,180	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet C Part I Date/Time Prepared: 2/27/2017 8:38 am

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		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	65,444,032		65,444,032			30.00
31.00	03100	INTENSIVE CARE UNIT	19,065,027		19,065,027			31.00
40.00	04000	SUBPROVIDER - IPF	6,991,757		6,991,757			40.00
41.00	04100	SUBPROVIDER - IRF	16,789,294		16,789,294			41.00
42.00	04200	SUBPROVIDER	0		0			42.00
43.00	04300	NURSERY	10,831,193		10,831,193			43.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
45.00	04500	NURSING FACILITY	0		0			45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	80,140,399	105,652,046	185,792,445	0.197715	0.000000	50.00
51.00	05100	RECOVERY ROOM	15,883,703	12,037,662	27,921,365	0.096050	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	9,083,574	926,102	10,009,676	0.786221	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	40,581,141	117,201,486	157,782,627	0.176106	0.000000	54.00
54.01	05401	ULTRASOUND	8,430,352	19,434,130	27,864,482	0.094231	0.000000	54.01
57.00	05700	CT SCAN	34,198,391	77,064,286	111,262,677	0.034240	0.000000	57.00
58.00	05800	MRI	9,709,662	21,689,562	31,399,224	0.078382	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	68,200,756	109,885,818	178,086,574	0.078975	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	6,812,591	2,800,145	9,612,736	0.259785	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	14,085,984	2,379,163	16,465,147	0.205250	0.000000	65.00
65.01	06501	SLEEP LAB	0	3,795,912	3,795,912	0.153135	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	9,248,898	395,419	9,644,317	0.329300	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,552,368	7,522,886	12,075,254	0.347483	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	11,928,172	9,925,978	21,854,150	0.113210	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	710,791	1,984,329	2,695,120	0.236033	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	26,959,023	11,451,679	38,410,702	0.522731	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	33,124,821	14,879,139	48,003,960	0.501270	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	49,407,448	22,457,577	71,865,025	0.326368	0.000000	73.00
74.00	07400	RENAL DIALYSIS	4,155,123	15,230	4,170,353	0.308564	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0.000000	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	0.000000	89.00
90.00	09000	CLINIC	16,762	827,556	844,318	1.159737	0.000000	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0.000000	0.000000	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0.000000	0.000000	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0	0.000000	0.000000	90.03
91.00	09100	EMERGENCY	28,382,367	70,470,225	98,852,592	0.198103	0.000000	91.00
91.01	09101	OP MENTAL HEALTH	0	2,250,386	2,250,386	0.482922	0.000000	91.01
91.02	09102	DIABETES CENTER	71,522	338,816	410,338	1.207383	0.000000	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,298,461	8,785,135	10,083,596	0.829010	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0.000000	0.000000	94.00
99.00	09900	CMHC	0	0	0			99.00
99.10	09910	CORF	0	0	0			99.10
101.00	10100	HOME HEALTH AGENCY	0	6,334,138	6,334,138			101.00
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0			109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0			110.00
111.00	11100	ISLET ACQUISITION	0	0	0			111.00
200.00		Subtotal (see instructions)	576,103,612	630,504,805	1,206,608,417			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	576,103,612	630,504,805	1,206,608,417			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet C Part I Date/Time Prepared: 2/27/2017 8:38 am

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
41.00	04100	SUBPROVIDER - IRF			41.00
42.00	04200	SUBPROVIDER			42.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
45.00	04500	NURSING FACILITY			45.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0.197725		50.00
51.00	05100	RECOVERY ROOM	0.096050		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.786221		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.176106		54.00
54.01	05401	ULTRASOUND	0.094231		54.01
57.00	05700	CT SCAN	0.034240		57.00
58.00	05800	MRI	0.078382		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.078980		60.00
60.01	06001	BLOOD LABORATORY	0.000000		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.259785		63.00
65.00	06500	RESPIRATORY THERAPY	0.205603		65.00
65.01	06501	SLEEP LAB	0.153135		65.01
66.00	06600	PHYSICAL THERAPY	0.329300		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.347483		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.113210		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.236033		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.522731		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.501270		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.326368		73.00
74.00	07400	RENAL DIALYSIS	0.310114		74.00
		OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
90.00	09000	CLINIC	1.159737		90.00
90.01	09001	HOMER GLEN LAB	0.000000		90.01
90.02	09002	HOMER GLEN FEC	0.000000		90.02
90.03	09003	WOMEN'S HEALTH	0.000000		90.03
91.00	09100	EMERGENCY	0.198263		91.00
91.01	09101	OP MENTAL HEALTH	0.482922		91.01
91.02	09102	DIABETES CENTER	1.208979		91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.829010		92.00
		OTHER REIMBURSABLE COST CENTERS			
94.00	09400	HOME PROGRAM DIALYSIS	0.000000		94.00
99.00	09900	CMHC			99.00
99.10	09910	CORF			99.10
101.00	10100	HOME HEALTH AGENCY			101.00
		SPECIAL PURPOSE COST CENTERS			
109.00	10900	PANCREAS ACQUISITION			109.00
110.00	11000	INTESTINAL ACQUISITION			110.00
111.00	11100	ISLET ACQUISITION			111.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

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

Provider CCN: 14-0213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet C Part II | Date/Time Prepared: 2/27/2017 8:38 am

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	36,733,905	5,481,192	31,252,713	0	0	50.00
51.00	05100	RECOVERY ROOM	2,681,837	295,563	2,386,274	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,869,820	619,133	7,250,687	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	27,786,452	4,179,747	23,606,705	0	0	54.00
54.01	05401	ULTRASOUND	2,625,706	394,195	2,231,511	0	0	54.01
57.00	05700	CT SCAN	3,809,660	679,539	3,130,121	0	0	57.00
58.00	05800	MRI	2,461,121	504,778	1,956,343	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	14,064,435	704,732	13,359,703	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,497,248	103,863	2,393,385	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	3,379,468	258,680	3,120,788	0	0	65.00
65.01	06501	SLEEP LAB	581,288	51,047	530,241	0	0	65.01
66.00	06600	PHYSICAL THERAPY	3,175,874	158,328	3,017,546	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,195,944	172,931	4,023,013	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,474,100	226,210	2,247,890	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	636,136	72,200	563,936	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	20,078,457	1,214,818	18,863,639	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	24,062,935	885,331	23,177,604	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	23,454,453	1,738,712	21,715,741	0	0	73.00
74.00	07400	RENAL DIALYSIS	1,286,819	191,752	1,095,067	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	979,187	40,765	938,422	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	19,583,025	2,345,916	17,237,109	0	0	91.00
91.01	09101	OP MENTAL HEALTH	1,086,760	155,238	931,522	0	0	91.01
91.02	09102	DIABETES CENTER	495,435	20,511	474,924	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	8,359,406	1,039,567	7,319,839	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	5,057,860	197,946	4,859,914	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
200.00		Subtotal (sum of lines 50 thru 199)	219,417,331	21,732,694	197,684,637	0	0	200.00
201.00		Less Observation Beds	8,359,406	1,039,567	7,319,839	0	0	201.00
202.00		Total (line 200 minus line 201)	211,057,925	20,693,127	190,364,798	0	0	202.00

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

Provider CCN: 14-0213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet C Part II Date/Time Prepared: 2/27/2017 8:38 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		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	36,733,905	185,792,445	0.197715		50.00
51.00	05100	RECOVERY ROOM	2,681,837	27,921,365	0.096050		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,869,820	10,009,676	0.786221		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	27,786,452	157,782,627	0.176106		54.00
54.01	05401	ULTRASOUND	2,625,706	27,864,482	0.094231		54.01
57.00	05700	CT SCAN	3,809,660	111,262,677	0.034240		57.00
58.00	05800	MRI	2,461,121	31,399,224	0.078382		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000		59.00
60.00	06000	LABORATORY	14,064,435	178,086,574	0.078975		60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,497,248	9,612,736	0.259785		63.00
65.00	06500	RESPIRATORY THERAPY	3,379,468	16,465,147	0.205250		65.00
65.01	06501	SLEEP LAB	581,288	3,795,912	0.153135		65.01
66.00	06600	PHYSICAL THERAPY	3,175,874	9,644,317	0.329300		66.00
67.00	06700	OCCUPATIONAL THERAPY	4,195,944	12,075,254	0.347483		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	2,474,100	21,854,150	0.113210		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	636,136	2,695,120	0.236033		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	20,078,457	38,410,702	0.522731		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	24,062,935	48,003,960	0.501270		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	23,454,453	71,865,025	0.326368		73.00
74.00	07400	RENAL DIALYSIS	1,286,819	4,170,353	0.308564		74.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000		89.00
90.00	09000	CLINIC	979,187	844,318	1.159737		90.00
90.01	09001	HOMER GLEN LAB	0	0	0.000000		90.01
90.02	09002	HOMER GLEN FEC	0	0	0.000000		90.02
90.03	09003	WOMEN'S HEALTH	0	0	0.000000		90.03
91.00	09100	EMERGENCY	19,583,025	98,852,592	0.198103		91.00
91.01	09101	OP MENTAL HEALTH	1,086,760	2,250,386	0.482922		91.01
91.02	09102	DIABETES CENTER	495,435	410,338	1.207383		91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	8,359,406	10,083,596	0.829010		92.00
		OTHER REIMBURSABLE COST CENTERS					
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0.000000		94.00
99.00	09900	CMHC	0	0	0.000000		99.00
99.10	09910	CORF	0	0	0.000000		99.10
101.00	10100	HOME HEALTH AGENCY	5,057,860	6,334,138	0.798508		101.00
		SPECIAL PURPOSE COST CENTERS					
109.00	10900	PANCREAS ACQUISITION	0	0	0.000000		109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0.000000		110.00
111.00	11100	ISLET ACQUISITION	0	0	0.000000		111.00
200.00		Subtotal (sum of lines 50 thru 199)	219,417,331	1,087,487,114			200.00
201.00		Less Observation Beds	8,359,406	0			201.00
202.00		Total (line 200 minus line 201)	211,057,925	1,087,487,114			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 14-0213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part I Date/Time Prepared: 2/27/2017 8:38 am

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	7,927,668	0	7,927,668	66,368	119.45	30.00
31.00	INTENSIVE CARE UNIT	1,594,014		1,594,014	7,120	223.88	31.00
40.00	SUBPROVIDER - IPF	675,494	0	675,494	6,211	108.76	40.00
41.00	SUBPROVIDER - IRF	1,290,129	0	1,290,129	8,075	159.77	41.00
42.00	SUBPROVIDER	0	0	0	0	0.00	42.00
43.00	NURSERY	2,167,906		2,167,906	7,605	285.06	43.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
45.00	NURSING FACILITY	0		0	0	0.00	45.00
200.00	Total (lines 30-199)	13,655,211		13,655,211	95,379		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	26,604	3,177,848	30.00
31.00	INTENSIVE CARE UNIT	3,379	756,491	31.00
40.00	SUBPROVIDER - IPF	1,415	153,895	40.00
41.00	SUBPROVIDER - IRF	5,214	833,041	41.00
42.00	SUBPROVIDER	0	0	42.00
43.00	NURSERY	0	0	43.00
44.00	SKILLED NURSING FACILITY	0	0	44.00
45.00	NURSING FACILITY	0	0	45.00
200.00	Total (lines 30-199)	36,612	4,921,275	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-0213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part II Date/Time Prepared: 2/27/2017 8:38 am

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,481,192	185,792,445	0.029502	22,513,777	664,201	50.00
51.00	05100	RECOVERY ROOM	295,563	27,921,365	0.010586	3,811,209	40,345	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	619,133	10,009,676	0.061853	21,580	1,335	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,179,747	157,782,627	0.026491	18,406,008	487,594	54.00
54.01	05401	ULTRASOUND	394,195	27,864,482	0.014147	3,910,666	55,324	54.01
57.00	05700	CT SCAN	679,539	111,262,677	0.006108	16,091,485	98,287	57.00
58.00	05800	MRI	504,778	31,399,224	0.016076	4,452,654	71,581	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	704,732	178,086,574	0.003957	30,674,367	121,378	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	103,863	9,612,736	0.010805	2,546,428	27,514	63.00
65.00	06500	RESPIRATORY THERAPY	258,680	16,465,147	0.015711	6,771,329	106,384	65.00
65.01	06501	SLEEP LAB	51,047	3,795,912	0.013448	0	0	65.01
66.00	06600	PHYSICAL THERAPY	158,328	9,644,317	0.016417	3,514,315	57,695	66.00
67.00	06700	OCCUPATIONAL THERAPY	172,931	12,075,254	0.014321	1,907,525	27,318	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	226,210	21,854,150	0.010351	6,385,353	66,095	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	72,200	2,695,120	0.026789	371,511	9,952	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,214,818	38,410,702	0.031627	17,625,757	557,450	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	885,331	48,003,960	0.018443	13,234,789	244,089	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,738,712	71,865,025	0.024194	17,139,530	414,674	73.00
74.00	07400	RENAL DIALYSIS	191,752	4,170,353	0.045980	2,298,247	105,673	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	40,765	844,318	0.048282	247	12	90.00
90.01	09001	HOMER GLEN LAB	0	0	0.000000	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0.000000	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0.000000	0	0	90.03
91.00	09100	EMERGENCY	2,345,916	98,852,592	0.023731	12,667,166	300,605	91.00
91.01	09101	OP MENTAL HEALTH	155,238	2,250,386	0.068983	0	0	91.01
91.02	09102	DIABETES CENTER	20,511	410,338	0.049986	16,852	842	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,039,567	10,083,596	0.103095	478,546	49,336	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)	21,534,748	1,081,152,976		184,839,341	3,507,684	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part III Date/Time Prepared: 2/27/2017 8:38 am

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		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	47,246	0		47,246	31.00
40.00	04000	SUBPROVIDER - IPF	0	30,663	0	0	30,663	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	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0			0	44.00
45.00	04500	NURSING FACILITY	0	0			0	45.00
200.00		Total (lines 30-199)	0	77,909	0		77,909	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	66,368	0.00	26,604	0		30.00
31.00	03100	INTENSIVE CARE UNIT	7,120	6.64	3,379	22,437		31.00
40.00	04000	SUBPROVIDER - IPF	6,211	4.94	1,415	6,990		40.00
41.00	04100	SUBPROVIDER - IRF	8,075	0.00	5,214	0		41.00
42.00	04200	SUBPROVIDER	0	0.00	0	0		42.00
43.00	04300	NURSERY	7,605	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)	95,379		36,612	29,427		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part IV | Date/Time Prepared: 2/27/2017 8:38 am

Title XVIII | Hospital | 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	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	27,534	0	27,534	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	28,785	0	28,785	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	23,154	0	23,154	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	791,835	0	791,835	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
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
200.00		Total (lines 50-199)	0	0	871,308	0	871,308	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part IV Date/Time Prepared: 2/27/2017 8:38 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)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	185,792,445	0.000000	0.000000	22,513,777	50.00
51.00	05100	RECOVERY ROOM	0	27,921,365	0.000000	0.000000	3,811,209	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	27,534	10,009,676	0.002751	0.002751	21,580	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	157,782,627	0.000000	0.000000	18,406,008	54.00
54.01	05401	ULTRASOUND	0	27,864,482	0.000000	0.000000	3,910,666	54.01
57.00	05700	CT SCAN	0	111,262,677	0.000000	0.000000	16,091,485	57.00
58.00	05800	MRI	0	31,399,224	0.000000	0.000000	4,452,654	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	178,086,574	0.000000	0.000000	30,674,367	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	9,612,736	0.000000	0.000000	2,546,428	63.00
65.00	06500	RESPIRATORY THERAPY	28,785	16,465,147	0.001748	0.001748	6,771,329	65.00
65.01	06501	SLEEP LAB	0	3,795,912	0.000000	0.000000	0	65.01
66.00	06600	PHYSICAL THERAPY	0	9,644,317	0.000000	0.000000	3,514,315	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	12,075,254	0.000000	0.000000	1,907,525	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	23,154	21,854,150	0.001059	0.001059	6,385,353	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2,695,120	0.000000	0.000000	371,511	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	38,410,702	0.000000	0.000000	17,625,757	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	48,003,960	0.000000	0.000000	13,234,789	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	71,865,025	0.000000	0.000000	17,139,530	73.00
74.00	07400	RENAL DIALYSIS	0	4,170,353	0.000000	0.000000	2,298,247	74.00
		OUTPATIENT SERVICE COST CENTERS						
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	844,318	0.000000	0.000000	247	90.00
90.01	09001	HOMER GLEN LAB	0	0	0.000000	0.000000	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0.000000	0.000000	0	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0.000000	0.000000	0	90.03
91.00	09100	EMERGENCY	791,835	98,852,592	0.008010	0.008010	12,667,166	91.00
91.01	09101	OP MENTAL HEALTH	0	2,250,386	0.000000	0.000000	0	91.01
91.02	09102	DIABETES CENTER	0	410,338	0.000000	0.000000	16,852	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	10,083,596	0.000000	0.000000	478,546	92.00
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0.000000	0.000000	0	94.00
200.00		Total (lines 50-199)	871,308	1,081,152,976			184,839,341	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part IV Date/Time Prepared: 2/27/2017 8:38 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)		
			11.00	12.00	13.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0	19,668,392	0		50.00
51.00	05100	RECOVERY ROOM	0	2,039,110	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	59	2,240	6		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	39,218,678	0		54.00
54.01	05401	ULTRASOUND	0	3,118,568	0		54.01
57.00	05700	CT SCAN	0	20,286,780	0		57.00
58.00	05800	MRI	0	5,233,988	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00	06000	LABORATORY	0	11,144,813	0		60.00
60.01	06001	BLOOD LABORATORY	0	0	0		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	668,300	0		63.00
65.00	06500	RESPIRATORY THERAPY	11,836	590,338	1,032		65.00
65.01	06501	SLEEP LAB	0	409,122	0		65.01
66.00	06600	PHYSICAL THERAPY	0	66,408	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	19,083	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	6,762	3,090,115	3,272		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	1,004,077	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	8,368,648	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,218,738	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,681,344	0		73.00
74.00	07400	RENAL DIALYSIS	0	15,225	0		74.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	09000	CLINIC	0	478,098	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	101,464	10,223,866	81,893		91.00
91.01	09101	OP MENTAL HEALTH	0	229,252	0		91.01
91.02	09102	DIABETES CENTER	0	45,911	0		91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	2,460,638	0		92.00
		OTHER REIMBURSABLE COST CENTERS					
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0		94.00
200.00		Total (lines 50-199)	120,121	139,281,732	86,203		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part V Date/Time Prepared: 2/27/2017 8:38 am

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		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.197715	19,668,392	0	0	3,888,736	50.00
51.00	05100	RECOVERY ROOM	0.096050	2,039,110	0	0	195,857	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.786221	2,240	0	0	1,761	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.176106	39,218,678	40	1,353	6,906,645	54.00
54.01	05401	ULTRASOUND	0.094231	3,118,568	0	0	293,866	54.01
57.00	05700	CT SCAN	0.034240	20,286,780	0	2,109	694,619	57.00
58.00	05800	MRI	0.078382	5,233,988	0	585	410,250	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.078975	11,144,813	3,098	0	880,162	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.259785	668,300	361	0	173,614	63.00
65.00	06500	RESPIRATORY THERAPY	0.205250	590,338	0	0	121,167	65.00
65.01	06501	SLEEP LAB	0.153135	409,122	0	0	62,651	65.01
66.00	06600	PHYSICAL THERAPY	0.329300	66,408	0	0	21,868	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.347483	19,083	0	0	6,631	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.113210	3,090,115	0	0	349,832	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.236033	1,004,077	0	0	236,995	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.522731	8,368,648	0	48	4,374,552	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.501270	5,218,738	86,197	0	2,615,997	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.326368	5,681,344	0	40,804	1,854,209	73.00
74.00	07400	RENAL DIALYSIS	0.308564	15,225	0	0	4,698	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
90.00	09000	CLINIC	1.159737	478,098	0	0	554,468	90.00
90.01	09001	HOMER GLEN LAB	0.000000	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0.000000	0	0	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0.000000	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.198103	10,223,866	1	136	2,025,379	91.00
91.01	09101	OP MENTAL HEALTH	0.482922	229,252	0	0	110,711	91.01
91.02	09102	DIABETES CENTER	1.207383	45,911	0	0	55,432	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.829010	2,460,638	0	0	2,039,894	92.00
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0.000000		0			94.00
200.00		Subtotal (see instructions)		139,281,732	89,697	45,035	27,879,994	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		139,281,732	89,697	45,035	27,879,994	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part V Date/Time Prepared: 2/27/2017 8:38 am

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		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
			6.00	7.00		
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	7	238		54.00
54.01	05401	ULTRASOUND	0	0		54.01
57.00	05700	CT SCAN	0	72		57.00
58.00	05800	MRI	0	46		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	245	0		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	94	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	25		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	43,208	0		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	13,317		73.00
74.00	07400	RENAL DIALYSIS	0	0		74.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	HOMER GLEN LAB	0	0		90.01
90.02	09002	HOMER GLEN FEC	0	0		90.02
90.03	09003	WOMEN'S HEALTH	0	0		90.03
91.00	09100	EMERGENCY	0	27		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
		OTHER REIMBURSABLE COST CENTERS				
94.00	09400	HOME PROGRAM DIALYSIS	0	0		94.00
200.00		Subtotal (see instructions)	43,554	13,725		200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0			201.00
202.00		Net Charges (line 200 +/- line 201)	43,554	13,725		202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0213 | Component CCN: 14-S213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part II | Date/Time Prepared: 2/27/2017 8:38 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	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,481,192	185,792,445	0.029502	16,416	484	50.00
51.00	05100	RECOVERY ROOM	295,563	27,921,365	0.010586	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	619,133	10,009,676	0.061853	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,179,747	157,782,627	0.026491	15,441	409	54.00
54.01	05401	ULTRASOUND	394,195	27,864,482	0.014147	9,800	139	54.01
57.00	05700	CT SCAN	679,539	111,262,677	0.006108	14,337	88	57.00
58.00	05800	MRI	504,778	31,399,224	0.016076	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	704,732	178,086,574	0.003957	247,460	979	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	103,863	9,612,736	0.010805	6,368	69	63.00
65.00	06500	RESPIRATORY THERAPY	258,680	16,465,147	0.015711	19,084	300	65.00
65.01	06501	SLEEP LAB	51,047	3,795,912	0.013448	0	0	65.01
66.00	06600	PHYSICAL THERAPY	158,328	9,644,317	0.016417	6,972	114	66.00
67.00	06700	OCCUPATIONAL THERAPY	172,931	12,075,254	0.014321	1,538	22	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	226,210	21,854,150	0.010351	11,044	114	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	72,200	2,695,120	0.026789	2,291	61	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,214,818	38,410,702	0.031627	4,909	155	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	885,331	48,003,960	0.018443	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,738,712	71,865,025	0.024194	96,931	2,345	73.00
74.00	07400	RENAL DIALYSIS	191,752	4,170,353	0.045980	3,261	150	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	40,765	844,318	0.048282	0	0	90.00
90.01	09001	HOMER GLEN LAB	0	0	0.000000	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0.000000	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0.000000	0	0	90.03
91.00	09100	EMERGENCY	2,345,916	98,852,592	0.023731	208,721	4,953	91.00
91.01	09101	OP MENTAL HEALTH	155,238	2,250,386	0.068983	0	0	91.01
91.02	09102	DIABETES CENTER	20,511	410,338	0.049986	797	40	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	10,083,596	0.000000	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0.000000	0	0	94.00
200.00		Total (lines 50-199)	20,495,181	1,081,152,976		665,370	10,422	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0213 | Component CCN: 14-S213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part IV Date/Time Prepared: 2/27/2017 8:38 am

Title XVIII | 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	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	27,534	0	27,534	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	28,785	0	28,785	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	23,154	0	23,154	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	791,835	0	791,835	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
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
200.00		Total (lines 50-199)	0	0	871,308	0	871,308	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0213 | Component CCN: 14-S213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part IV Date/Time Prepared: 2/27/2017 8:38 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	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	185,792,445	0.000000	0.000000	16,416	50.00
51.00	05100	RECOVERY ROOM	0	27,921,365	0.000000	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	27,534	10,009,676	0.002751	0.002751	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	157,782,627	0.000000	0.000000	15,441	54.00
54.01	05401	ULTRASOUND	0	27,864,482	0.000000	0.000000	9,800	54.01
57.00	05700	CT SCAN	0	111,262,677	0.000000	0.000000	14,337	57.00
58.00	05800	MRI	0	31,399,224	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	178,086,574	0.000000	0.000000	247,460	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	9,612,736	0.000000	0.000000	6,368	63.00
65.00	06500	RESPIRATORY THERAPY	28,785	16,465,147	0.001748	0.001748	19,084	65.00
65.01	06501	SLEEP LAB	0	3,795,912	0.000000	0.000000	0	65.01
66.00	06600	PHYSICAL THERAPY	0	9,644,317	0.000000	0.000000	6,972	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	12,075,254	0.000000	0.000000	1,538	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	23,154	21,854,150	0.001059	0.001059	11,044	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2,695,120	0.000000	0.000000	2,291	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	38,410,702	0.000000	0.000000	4,909	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	48,003,960	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	71,865,025	0.000000	0.000000	96,931	73.00
74.00	07400	RENAL DIALYSIS	0	4,170,353	0.000000	0.000000	3,261	74.00
		OUTPATIENT SERVICE COST CENTERS						
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	844,318	0.000000	0.000000	0	90.00
90.01	09001	HOMER GLEN LAB	0	0	0.000000	0.000000	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0.000000	0.000000	0	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0.000000	0.000000	0	90.03
91.00	09100	EMERGENCY	791,835	98,852,592	0.008010	0.008010	208,721	91.00
91.01	09101	OP MENTAL HEALTH	0	2,250,386	0.000000	0.000000	0	91.01
91.02	09102	DIABETES CENTER	0	410,338	0.000000	0.000000	797	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	10,083,596	0.000000	0.000000	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0.000000	0.000000	0	94.00
200.00		Total (lines 50-199)	871,308	1,081,152,976			665,370	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0213 | Component CCN: 14-S213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part IV Date/Time Prepared: 2/27/2017 8:38 am

Title XVIII | 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		
		ANCILLARY SERVICE COST CENTERS					
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	33	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	12	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
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	09000	CLINIC	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	1,672	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
		OTHER REIMBURSABLE COST CENTERS					
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0		94.00
200.00		Total (lines 50-199)	1,717	0	0		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0213 | Component CCN: 14-T213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part II | Date/Time Prepared: 2/27/2017 8:38 am

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,481,192	185,792,445	0.029502	154,841	4,568	50.00
51.00	05100	RECOVERY ROOM	295,563	27,921,365	0.010586	2,567	27	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	619,133	10,009,676	0.061853	6	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,179,747	157,782,627	0.026491	232,100	6,149	54.00
54.01	05401	ULTRASOUND	394,195	27,864,482	0.014147	87,097	1,232	54.01
57.00	05700	CT SCAN	679,539	111,262,677	0.006108	215,140	1,314	57.00
58.00	05800	MRI	504,778	31,399,224	0.016076	73,432	1,180	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	704,732	178,086,574	0.003957	1,084,839	4,293	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	103,863	9,612,736	0.010805	65,469	707	63.00
65.00	06500	RESPIRATORY THERAPY	258,680	16,465,147	0.015711	294,188	4,622	65.00
65.01	06501	SLEEP LAB	51,047	3,795,912	0.013448	0	0	65.01
66.00	06600	PHYSICAL THERAPY	158,328	9,644,317	0.016417	2,725,842	44,750	66.00
67.00	06700	OCCUPATIONAL THERAPY	172,931	12,075,254	0.014321	2,643,295	37,855	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	226,210	21,854,150	0.010351	40,479	419	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	72,200	2,695,120	0.026789	7,213	193	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,214,818	38,410,702	0.031627	509,031	16,099	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	885,331	48,003,960	0.018443	2,236	41	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,738,712	71,865,025	0.024194	693,391	16,776	73.00
74.00	07400	RENAL DIALYSIS	191,752	4,170,353	0.045980	251,823	11,579	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	40,765	844,318	0.048282	0	0	90.00
90.01	09001	HOMER GLEN LAB	0	0	0.000000	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0.000000	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0.000000	0	0	90.03
91.00	09100	EMERGENCY	2,345,916	98,852,592	0.023731	416	10	91.00
91.01	09101	OP MENTAL HEALTH	155,238	2,250,386	0.068983	0	0	91.01
91.02	09102	DIABETES CENTER	20,511	410,338	0.049986	1,855	93	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	10,083,596	0.000000	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0.000000	0	0	94.00
200.00		Total (lines 50-199)	20,495,181	1,081,152,976		9,085,260	151,907	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0213 | Component CCN: 14-T213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part IV Date/Time Prepared: 2/27/2017 8:38 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	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	27,534	0	27,534	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	28,785	0	28,785	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	23,154	0	23,154	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	791,835	0	791,835	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
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
200.00		Total (lines 50-199)	0	0	871,308	0	871,308	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0213 | Component CCN: 14-T213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part IV | Date/Time Prepared: 2/27/2017 8:38 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	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	185,792,445	0.000000	0.000000	154,841	50.00
51.00	05100	RECOVERY ROOM	0	27,921,365	0.000000	0.000000	2,567	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	27,534	10,009,676	0.002751	0.002751	6	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	157,782,627	0.000000	0.000000	232,100	54.00
54.01	05401	ULTRASOUND	0	27,864,482	0.000000	0.000000	87,097	54.01
57.00	05700	CT SCAN	0	111,262,677	0.000000	0.000000	215,140	57.00
58.00	05800	MRI	0	31,399,224	0.000000	0.000000	73,432	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	178,086,574	0.000000	0.000000	1,084,839	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	9,612,736	0.000000	0.000000	65,469	63.00
65.00	06500	RESPIRATORY THERAPY	28,785	16,465,147	0.001748	0.001748	294,188	65.00
65.01	06501	SLEEP LAB	0	3,795,912	0.000000	0.000000	0	65.01
66.00	06600	PHYSICAL THERAPY	0	9,644,317	0.000000	0.000000	2,725,842	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	12,075,254	0.000000	0.000000	2,643,295	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	23,154	21,854,150	0.001059	0.001059	40,479	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2,695,120	0.000000	0.000000	7,213	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	38,410,702	0.000000	0.000000	509,031	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	48,003,960	0.000000	0.000000	2,236	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	71,865,025	0.000000	0.000000	693,391	73.00
74.00	07400	RENAL DIALYSIS	0	4,170,353	0.000000	0.000000	251,823	74.00
		OUTPATIENT SERVICE COST CENTERS						
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	844,318	0.000000	0.000000	0	90.00
90.01	09001	HOMER GLEN LAB	0	0	0.000000	0.000000	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0.000000	0.000000	0	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0.000000	0.000000	0	90.03
91.00	09100	EMERGENCY	791,835	98,852,592	0.008010	0.008010	416	91.00
91.01	09101	OP MENTAL HEALTH	0	2,250,386	0.000000	0.000000	0	91.01
91.02	09102	DIABETES CENTER	0	410,338	0.000000	0.000000	1,855	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	10,083,596	0.000000	0.000000	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0.000000	0.000000	0	94.00
200.00		Total (lines 50-199)	871,308	1,081,152,976			9,085,260	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0213 | Component CCN: 14-T213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part IV Date/Time Prepared: 2/27/2017 8:38 am

Title XVIII | 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		
		ANCILLARY SERVICE COST CENTERS					
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	514	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	43	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
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	09000	CLINIC	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	3	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
		OTHER REIMBURSABLE COST CENTERS					
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0		94.00
200.00		Total (lines 50-199)	560	0	0		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

Provider CCN: 14-0213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part I Date/Time Prepared: 2/27/2017 8:38 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	7,927,668	0	7,927,668	66,368	119.45	30.00
31.00	INTENSIVE CARE UNIT	1,594,014		1,594,014	7,120	223.88	31.00
40.00	SUBPROVIDER - IPF	675,494	0	675,494	6,211	108.76	40.00
41.00	SUBPROVIDER - IRF	1,290,129	0	1,290,129	8,075	159.77	41.00
42.00	SUBPROVIDER	0	0	0	0	0.00	42.00
43.00	NURSERY	2,167,906		2,167,906	7,605	285.06	43.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
45.00	NURSING FACILITY	0		0	0	0.00	45.00
200.00	Total (lines 30-199)	13,655,211		13,655,211	95,379		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	4,721	563,923		30.00
31.00	INTENSIVE CARE UNIT	583	130,522		31.00
40.00	SUBPROVIDER - IPF	627	68,193		40.00
41.00	SUBPROVIDER - IRF	82	13,101		41.00
42.00	SUBPROVIDER	0	0		42.00
43.00	NURSERY	623	177,592		43.00
44.00	SKILLED NURSING FACILITY	0	0		44.00
45.00	NURSING FACILITY	0	0		45.00
200.00	Total (lines 30-199)	6,636	953,331		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-0213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part II Date/Time Prepared: 2/27/2017 8:38 am

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,481,192	185,792,445	0.029502	0	0	50.00
51.00	05100	RECOVERY ROOM	295,563	27,921,365	0.010586	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	619,133	10,009,676	0.061853	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,179,747	157,782,627	0.026491	0	0	54.00
54.01	05401	ULTRASOUND	394,195	27,864,482	0.014147	0	0	54.01
57.00	05700	CT SCAN	679,539	111,262,677	0.006108	0	0	57.00
58.00	05800	MRI	504,778	31,399,224	0.016076	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	704,732	178,086,574	0.003957	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	103,863	9,612,736	0.010805	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	258,680	16,465,147	0.015711	0	0	65.00
65.01	06501	SLEEP LAB	51,047	3,795,912	0.013448	0	0	65.01
66.00	06600	PHYSICAL THERAPY	158,328	9,644,317	0.016417	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	172,931	12,075,254	0.014321	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	226,210	21,854,150	0.010351	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	72,200	2,695,120	0.026789	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,214,818	38,410,702	0.031627	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	885,331	48,003,960	0.018443	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,738,712	71,865,025	0.024194	0	0	73.00
74.00	07400	RENAL DIALYSIS	191,752	4,170,353	0.045980	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	40,765	844,318	0.048282	0	0	90.00
90.01	09001	HOMER GLEN LAB	0	0	0.000000	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0.000000	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0.000000	0	0	90.03
91.00	09100	EMERGENCY	2,345,916	98,852,592	0.023731	0	0	91.00
91.01	09101	OP MENTAL HEALTH	155,238	2,250,386	0.068983	0	0	91.01
91.02	09102	DIABETES CENTER	20,511	410,338	0.049986	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,039,567	10,083,596	0.103095	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0.000000	0	0	94.00
200.00		Total (lines 50-199)	21,534,748	1,081,152,976		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part III Date/Time Prepared: 2/27/2017 8:38 am

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	47,246	0		47,246	31.00
40.00	04000	SUBPROVIDER - IPF	0	30,663	0	0	30,663	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	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0			0	44.00
45.00	04500	NURSING FACILITY	0	0			0	45.00
200.00		Total (lines 30-199)	0	77,909	0		77,909	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	66,368	0.00	4,721	0		30.00
31.00	03100	INTENSIVE CARE UNIT	7,120	6.64	583	3,871		31.00
40.00	04000	SUBPROVIDER - IPF	6,211	4.94	627	3,097		40.00
41.00	04100	SUBPROVIDER - IRF	8,075	0.00	82	0		41.00
42.00	04200	SUBPROVIDER	0	0.00	0	0		42.00
43.00	04300	NURSERY	7,605	0.00	623	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)	95,379		6,636	6,968		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part IV | Date/Time Prepared: 2/27/2017 8:38 am

Title XIX | Hospital | 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	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	27,534	0	27,534	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	28,785	0	28,785	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	23,154	0	23,154	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	791,835	0	791,835	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
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
200.00		Total (lines 50-199)	0	0	871,308	0	871,308	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part IV Date/Time Prepared: 2/27/2017 8:38 am

Title XIX | Hospital | 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	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	185,792,445	0.000000	0.000000	0	50.00
51.00	05100	RECOVERY ROOM	0	27,921,365	0.000000	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	27,534	10,009,676	0.002751	0.002751	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	157,782,627	0.000000	0.000000	0	54.00
54.01	05401	ULTRASOUND	0	27,864,482	0.000000	0.000000	0	54.01
57.00	05700	CT SCAN	0	111,262,677	0.000000	0.000000	0	57.00
58.00	05800	MRI	0	31,399,224	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	178,086,574	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	9,612,736	0.000000	0.000000	0	63.00
65.00	06500	RESPIRATORY THERAPY	28,785	16,465,147	0.001748	0.001748	0	65.00
65.01	06501	SLEEP LAB	0	3,795,912	0.000000	0.000000	0	65.01
66.00	06600	PHYSICAL THERAPY	0	9,644,317	0.000000	0.000000	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	12,075,254	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	23,154	21,854,150	0.001059	0.001059	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2,695,120	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	38,410,702	0.000000	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	48,003,960	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	71,865,025	0.000000	0.000000	0	73.00
74.00	07400	RENAL DIALYSIS	0	4,170,353	0.000000	0.000000	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
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	844,318	0.000000	0.000000	0	90.00
90.01	09001	HOMER GLEN LAB	0	0	0.000000	0.000000	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0.000000	0.000000	0	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0.000000	0.000000	0	90.03
91.00	09100	EMERGENCY	791,835	98,852,592	0.008010	0.008010	0	91.00
91.01	09101	OP MENTAL HEALTH	0	2,250,386	0.000000	0.000000	0	91.01
91.02	09102	DIABETES CENTER	0	410,338	0.000000	0.000000	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	10,083,596	0.000000	0.000000	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0.000000	0.000000	0	94.00
200.00		Total (lines 50-199)	871,308	1,081,152,976			0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part IV Date/Time Prepared: 2/27/2017 8:38 am

Title XIX | 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		
		ANCILLARY SERVICE COST CENTERS					
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
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	09000	CLINIC	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
		OTHER REIMBURSABLE COST CENTERS					
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: 14-0213 | Component CCN: 14-S213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part II | Date/Time Prepared: 2/27/2017 8:38 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	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,481,192	185,792,445	0.029502	0	0	50.00
51.00	05100	RECOVERY ROOM	295,563	27,921,365	0.010586	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	619,133	10,009,676	0.061853	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,179,747	157,782,627	0.026491	0	0	54.00
54.01	05401	ULTRASOUND	394,195	27,864,482	0.014147	0	0	54.01
57.00	05700	CT SCAN	679,539	111,262,677	0.006108	0	0	57.00
58.00	05800	MRI	504,778	31,399,224	0.016076	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	704,732	178,086,574	0.003957	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	103,863	9,612,736	0.010805	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	258,680	16,465,147	0.015711	0	0	65.00
65.01	06501	SLEEP LAB	51,047	3,795,912	0.013448	0	0	65.01
66.00	06600	PHYSICAL THERAPY	158,328	9,644,317	0.016417	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	172,931	12,075,254	0.014321	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	226,210	21,854,150	0.010351	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	72,200	2,695,120	0.026789	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,214,818	38,410,702	0.031627	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	885,331	48,003,960	0.018443	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,738,712	71,865,025	0.024194	0	0	73.00
74.00	07400	RENAL DIALYSIS	191,752	4,170,353	0.045980	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	40,765	844,318	0.048282	0	0	90.00
90.01	09001	HOMER GLEN LAB	0	0	0.000000	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0.000000	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0.000000	0	0	90.03
91.00	09100	EMERGENCY	2,345,916	98,852,592	0.023731	0	0	91.00
91.01	09101	OP MENTAL HEALTH	155,238	2,250,386	0.068983	0	0	91.01
91.02	09102	DIABETES CENTER	20,511	410,338	0.049986	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	10,083,596	0.000000	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0.000000	0	0	94.00
200.00		Total (lines 50-199)	20,495,181	1,081,152,976		0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0213 | Component CCN: 14-S213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part IV Date/Time Prepared: 2/27/2017 8:38 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	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	27,534	0	27,534	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	28,785	0	28,785	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	23,154	0	23,154	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	791,835	0	791,835	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
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
200.00		Total (lines 50-199)	0	0	871,308	0	871,308	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0213 | Component CCN: 14-S213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part IV Date/Time Prepared: 2/27/2017 8:38 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	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	185,792,445	0.000000	0.000000	0	50.00
51.00	05100	RECOVERY ROOM	0	27,921,365	0.000000	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	27,534	10,009,676	0.002751	0.002751	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	157,782,627	0.000000	0.000000	0	54.00
54.01	05401	ULTRASOUND	0	27,864,482	0.000000	0.000000	0	54.01
57.00	05700	CT SCAN	0	111,262,677	0.000000	0.000000	0	57.00
58.00	05800	MRI	0	31,399,224	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	178,086,574	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	9,612,736	0.000000	0.000000	0	63.00
65.00	06500	RESPIRATORY THERAPY	28,785	16,465,147	0.001748	0.001748	0	65.00
65.01	06501	SLEEP LAB	0	3,795,912	0.000000	0.000000	0	65.01
66.00	06600	PHYSICAL THERAPY	0	9,644,317	0.000000	0.000000	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	12,075,254	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	23,154	21,854,150	0.001059	0.001059	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2,695,120	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	38,410,702	0.000000	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	48,003,960	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	71,865,025	0.000000	0.000000	0	73.00
74.00	07400	RENAL DIALYSIS	0	4,170,353	0.000000	0.000000	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
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	844,318	0.000000	0.000000	0	90.00
90.01	09001	HOMER GLEN LAB	0	0	0.000000	0.000000	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0.000000	0.000000	0	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0.000000	0.000000	0	90.03
91.00	09100	EMERGENCY	791,835	98,852,592	0.008010	0.008010	0	91.00
91.01	09101	OP MENTAL HEALTH	0	2,250,386	0.000000	0.000000	0	91.01
91.02	09102	DIABETES CENTER	0	410,338	0.000000	0.000000	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	10,083,596	0.000000	0.000000	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0.000000	0.000000	0	94.00
200.00		Total (lines 50-199)	871,308	1,081,152,976			0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0213 | Component CCN: 14-S213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part IV Date/Time Prepared: 2/27/2017 8:38 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		
		ANCILLARY SERVICE COST CENTERS					
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
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	09000	CLINIC	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
		OTHER REIMBURSABLE COST CENTERS					
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: 14-0213 | Component CCN: 14-T213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part II | Date/Time Prepared: 2/27/2017 8:38 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	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	5,481,192	185,792,445	0.029502	0	0	50.00
51.00	05100	RECOVERY ROOM	295,563	27,921,365	0.010586	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	619,133	10,009,676	0.061853	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,179,747	157,782,627	0.026491	0	0	54.00
54.01	05401	ULTRASOUND	394,195	27,864,482	0.014147	0	0	54.01
57.00	05700	CT SCAN	679,539	111,262,677	0.006108	0	0	57.00
58.00	05800	MRI	504,778	31,399,224	0.016076	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	704,732	178,086,574	0.003957	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	103,863	9,612,736	0.010805	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	258,680	16,465,147	0.015711	0	0	65.00
65.01	06501	SLEEP LAB	51,047	3,795,912	0.013448	0	0	65.01
66.00	06600	PHYSICAL THERAPY	158,328	9,644,317	0.016417	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	172,931	12,075,254	0.014321	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	226,210	21,854,150	0.010351	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	72,200	2,695,120	0.026789	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,214,818	38,410,702	0.031627	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	885,331	48,003,960	0.018443	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,738,712	71,865,025	0.024194	0	0	73.00
74.00	07400	RENAL DIALYSIS	191,752	4,170,353	0.045980	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	40,765	844,318	0.048282	0	0	90.00
90.01	09001	HOMER GLEN LAB	0	0	0.000000	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0.000000	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0.000000	0	0	90.03
91.00	09100	EMERGENCY	2,345,916	98,852,592	0.023731	0	0	91.00
91.01	09101	OP MENTAL HEALTH	155,238	2,250,386	0.068983	0	0	91.01
91.02	09102	DIABETES CENTER	20,511	410,338	0.049986	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	10,083,596	0.000000	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0.000000	0	0	94.00
200.00		Total (lines 50-199)	20,495,181	1,081,152,976		0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0213 | Component CCN: 14-T213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part IV Date/Time Prepared: 2/27/2017 8:38 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	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	27,534	0	27,534	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	28,785	0	28,785	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	23,154	0	23,154	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	791,835	0	791,835	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
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
200.00		Total (lines 50-199)	0	0	871,308	0	871,308	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0213 | Component CCN: 14-T213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part IV Date/Time Prepared: 2/27/2017 8:38 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	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	185,792,445	0.000000	0.000000	0	50.00
51.00	05100	RECOVERY ROOM	0	27,921,365	0.000000	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	27,534	10,009,676	0.002751	0.002751	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	157,782,627	0.000000	0.000000	0	54.00
54.01	05401	ULTRASOUND	0	27,864,482	0.000000	0.000000	0	54.01
57.00	05700	CT SCAN	0	111,262,677	0.000000	0.000000	0	57.00
58.00	05800	MRI	0	31,399,224	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	178,086,574	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	9,612,736	0.000000	0.000000	0	63.00
65.00	06500	RESPIRATORY THERAPY	28,785	16,465,147	0.001748	0.001748	0	65.00
65.01	06501	SLEEP LAB	0	3,795,912	0.000000	0.000000	0	65.01
66.00	06600	PHYSICAL THERAPY	0	9,644,317	0.000000	0.000000	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	12,075,254	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	23,154	21,854,150	0.001059	0.001059	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2,695,120	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	38,410,702	0.000000	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	48,003,960	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	71,865,025	0.000000	0.000000	0	73.00
74.00	07400	RENAL DIALYSIS	0	4,170,353	0.000000	0.000000	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
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	844,318	0.000000	0.000000	0	90.00
90.01	09001	HOMER GLEN LAB	0	0	0.000000	0.000000	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0.000000	0.000000	0	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0.000000	0.000000	0	90.03
91.00	09100	EMERGENCY	791,835	98,852,592	0.008010	0.008010	0	91.00
91.01	09101	OP MENTAL HEALTH	0	2,250,386	0.000000	0.000000	0	91.01
91.02	09102	DIABETES CENTER	0	410,338	0.000000	0.000000	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	10,083,596	0.000000	0.000000	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0.000000	0.000000	0	94.00
200.00		Total (lines 50-199)	871,308	1,081,152,976			0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0213 | Component CCN: 14-T213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D Part IV | Date/Time Prepared: 2/27/2017 8:38 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		
		ANCILLARY SERVICE COST CENTERS					
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
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	09000	CLINIC	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
		OTHER REIMBURSABLE COST CENTERS					
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: 14-0213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-1 | Date/Time Prepared: 2/27/2017 8:38 am

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	66,368	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	66,368	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)	57,665	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)	26,604	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	63,748,067	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)	63,748,067	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	63,748,067	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	960.52	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	25,553,674	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	25,553,674	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-1 | Date/Time Prepared: 2/27/2017 8:38 am

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	14,680,756	7,120	2,061.90	3,379	6,967,160	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)	41,534,584	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	74,055,418	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)	3,956,776	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	3,627,805	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	7,584,581	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	66,470,837	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	8,703	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	960.52	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	8,359,406	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-1 | Date/Time Prepared: 2/27/2017 8:38 am

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	7,927,668	63,748,067	0.124359	8,359,406	1,039,567	90.00
91.00	Nursing School cost	0	63,748,067	0.000000	8,359,406	0	91.00
92.00	Allied health cost	0	63,748,067	0.000000	8,359,406	0	92.00
93.00	All other Medical Education	0	63,748,067	0.000000	8,359,406	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-0213 Component CCN: 14-S213	Period: From 10/01/2015 To 09/30/2016	Worksheet D-1 Date/Time Prepared: 2/27/2017 8:38 am
	Title XVIII	Subprovider - IPF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	6,211	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	6,211	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)	6,211	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)	1,415	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	5,140,984	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5,140,984	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	5,140,984	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	827.72	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	1,171,224	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)	1,171,224	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0213 | Component CCN: 14-S213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-1 | Date/Time Prepared: 2/27/2017 8:38 am

Title XVIII | Subprovider - IPF | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	114,680	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,285,904	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)	160,885	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	12,139	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	173,024	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	1,112,880	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-0213 Component CCN: 14-S213	Period: From 10/01/2015 To 09/30/2016	Worksheet D-1 Date/Time Prepared: 2/27/2017 8:38 am
	Title XVIII	Subprovider - IPF	PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	675,494	5,140,984	0.131394	0	0	90.00
91.00	Nursing School cost	0	5,140,984	0.000000	0	0	91.00
92.00	Allied health cost	30,663	5,140,984	0.005964	0	0	92.00
93.00	All other Medical Education	0	5,140,984	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-0213 Component CCN: 14-T213	Period: From 10/01/2015 To 09/30/2016	Worksheet D-1 Date/Time Prepared: 2/27/2017 8:38 am
	Title XVIII	Subprovider - IRF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	8,075	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	8,075	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	8,075	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	5,214	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	10,128,409	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	10,128,409	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	10,128,409	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,254.29	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	6,539,868	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)	6,539,868	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0213 | Component CCN: 14-T213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-1 | Date/Time Prepared: 2/27/2017 8:38 am

Title XVIII | Subprovider - IRF | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	2,652,579	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	9,192,447	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)	833,041	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	152,467	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	985,508	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	8,206,939	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0213 | Component CCN: 14-T213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-1 | Date/Time Prepared: 2/27/2017 8:38 am

Title XVIII | Subprovider - IRF | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,290,129	10,128,409	0.127377	0	0	90.00
91.00	Nursing School cost	0	10,128,409	0.000000	0	0	91.00
92.00	Allied health cost	0	10,128,409	0.000000	0	0	92.00
93.00	All other Medical Education	0	10,128,409	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-1 | Date/Time Prepared: 2/27/2017 8:38 am

Title XIX | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	66,368	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	66,368	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)	57,665	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)	4,721	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)	7,605	15.00
16.00	Nursery days (title V or XIX only)	623	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	63,748,067	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)	63,748,067	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	63,748,067	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	960.52	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	4,534,615	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)	4,534,615	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-1 | Date/Time Prepared: 2/27/2017 8:38 am

Title XIX | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	8,623,510	7,605	1,133.93	623	706,438	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	14,680,756	7,120	2,061.90	583	1,202,088	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)	6,443,141	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)	875,908	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)	875,908	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	5,567,233	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	8,703	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	960.52	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	8,359,406	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-1 | Date/Time Prepared: 2/27/2017 8:38 am

Title XIX | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	7,927,668	63,748,067	0.124359	8,359,406	1,039,567	90.00
91.00	Nursing School cost	0	63,748,067	0.000000	8,359,406	0	91.00
92.00	Allied health cost	0	63,748,067	0.000000	8,359,406	0	92.00
93.00	All other Medical Education	0	63,748,067	0.000000	8,359,406	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-0213 Component CCN: 14-S213	Period: From 10/01/2015 To 09/30/2016	Worksheet D-1 Date/Time Prepared: 2/27/2017 8:38 am
	Title XIX	Subprovider - IPF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	6,211	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	6,211	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)	6,211	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)	627	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)	7,605	15.00
16.00	Nursery days (title V or XIX only)	623	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	5,140,984	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	5,140,984	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	5,140,984	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	827.72	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	518,980	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)	518,980	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0213 | Component CCN: 14-S213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-1 | Date/Time Prepared: 2/27/2017 8:38 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
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	518,980	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)	71,290	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)	71,290	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	447,690	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0213 | Component CCN: 14-S213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-1 | Date/Time Prepared: 2/27/2017 8:38 am

Title XIX | Subprovider - IPF | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	675,494	5,140,984	0.131394	0	0	90.00
91.00	Nursing School cost	0	5,140,984	0.000000	0	0	91.00
92.00	Allied health cost	30,663	5,140,984	0.005964	0	0	92.00
93.00	All other Medical Education	0	5,140,984	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-0213 Component CCN: 14-T213	Period: From 10/01/2015 To 09/30/2016	Worksheet D-1 Date/Time Prepared: 2/27/2017 8:38 am
	Title XIX	Subprovider - IRF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	8,075	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	8,075	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	8,075	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)	82	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)	7,605	15.00
16.00	Nursery days (title V or XIX only)	623	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	10,128,409	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	10,128,409	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	10,128,409	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00	Adjusted general inpatient routine service cost per diem (see instructions)	1,254.29	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	102,852	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)	102,852	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0213 | Component CCN: 14-T213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-1 | Date/Time Prepared: 2/27/2017 8:38 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	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	102,852	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)	13,101	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)	13,101	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	89,751	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	0	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	0.00	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	0	89.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0213 | Component CCN: 14-T213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-1 | Date/Time Prepared: 2/27/2017 8:38 am

Title XIX | Subprovider - IRF | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	1,290,129	10,128,409	0.127377	0	0	90.00
91.00	Nursing School cost	0	10,128,409	0.000000	0	0	91.00
92.00	Allied health cost	0	10,128,409	0.000000	0	0	92.00
93.00	All other Medical Education	0	10,128,409	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-0213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-3 | Date/Time Prepared: 2/27/2017 8:38 am

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		30,552,516		30.00
31.00	03100	INTENSIVE CARE UNIT		9,469,104		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.197725	22,513,777	4,451,537	50.00
51.00	05100	RECOVERY ROOM	0.096050	3,811,209	366,067	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.786221	21,580	16,967	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.176106	18,406,008	3,241,408	54.00
54.01	05401	ULTRASOUND	0.094231	3,910,666	368,506	54.01
57.00	05700	CT SCAN	0.034240	16,091,485	550,972	57.00
58.00	05800	MRI	0.078382	4,452,654	349,008	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.078980	30,674,367	2,422,662	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.259785	2,546,428	661,524	63.00
65.00	06500	RESPIRATORY THERAPY	0.205603	6,771,329	1,392,206	65.00
65.01	06501	SLEEP LAB	0.153135	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.329300	3,514,315	1,157,264	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.347483	1,907,525	662,833	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.113210	6,385,353	722,886	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.236033	371,511	87,689	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.522731	17,625,757	9,213,530	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.501270	13,234,789	6,634,203	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.326368	17,139,530	5,593,794	73.00
74.00	07400	RENAL DIALYSIS	0.310114	2,298,247	712,719	74.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000	CLINIC	1.159737	247	286	90.00
90.01	09001	HOMER GLEN LAB	0.000000	0	0	90.01
90.02	09002	HOMER GLEN FEC	0.000000	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0.000000	0	0	90.03
91.00	09100	EMERGENCY	0.198263	12,667,166	2,511,430	91.00
91.01	09101	OP MENTAL HEALTH	0.482922	0	0	91.01
91.02	09102	DIABETES CENTER	1.208979	16,852	20,374	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.829010	478,546	396,719	92.00
		OTHER REIMBURSABLE COST CENTERS				
94.00	09400	HOME PROGRAM DIALYSIS	0.000000	0	0	94.00
200.00		Total (sum of lines 50-94 and 96-98)		184,839,341	41,534,584	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)		184,839,341		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-0213 | Component CCN: 14-S213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-3 | Date/Time Prepared: 2/27/2017 8:38 am

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		1,591,592		40.00
41.00	04100	SUBPROVIDER - IRF		0		41.00
42.00	04200	SUBPROVIDER		0		42.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.197725	16,416	3,246	50.00
51.00	05100	RECOVERY ROOM	0.096050	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.786221	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.176106	15,441	2,719	54.00
54.01	05401	ULTRASOUND	0.094231	9,800	923	54.01
57.00	05700	CT SCAN	0.034240	14,337	491	57.00
58.00	05800	MRI	0.078382	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.078980	247,460	19,544	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.259785	6,368	1,654	63.00
65.00	06500	RESPIRATORY THERAPY	0.205603	19,084	3,924	65.00
65.01	06501	SLEEP LAB	0.153135	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.329300	6,972	2,296	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.347483	1,538	534	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.113210	11,044	1,250	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.236033	2,291	541	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.522731	4,909	2,566	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.501270	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.326368	96,931	31,635	73.00
74.00	07400	RENAL DIALYSIS	0.310114	3,261	1,011	74.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000	CLINIC	1.159737	0	0	90.00
90.01	09001	HOMER GLEN LAB	0.000000	0	0	90.01
90.02	09002	HOMER GLEN FEC	0.000000	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0.000000	0	0	90.03
91.00	09100	EMERGENCY	0.198263	208,721	41,382	91.00
91.01	09101	OP MENTAL HEALTH	0.482922	0	0	91.01
91.02	09102	DIABETES CENTER	1.208979	797	964	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.829010	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
94.00	09400	HOME PROGRAM DIALYSIS	0.000000	0	0	94.00
200.00		Total (sum of lines 50-94 and 96-98)		665,370	114,680	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)		665,370		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-0213 | Component CCN: 14-T213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet D-3 | Date/Time Prepared: 2/27/2017 8:38 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	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		5,424,124		41.00
42.00	04200	SUBPROVIDER		0		42.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.197725	154,841	30,616	50.00
51.00	05100	RECOVERY ROOM	0.096050	2,567	247	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.786221	6	5	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.176106	232,100	40,874	54.00
54.01	05401	ULTRASOUND	0.094231	87,097	8,207	54.01
57.00	05700	CT SCAN	0.034240	215,140	7,366	57.00
58.00	05800	MRI	0.078382	73,432	5,756	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.078980	1,084,839	85,681	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.259785	65,469	17,008	63.00
65.00	06500	RESPIRATORY THERAPY	0.205603	294,188	60,486	65.00
65.01	06501	SLEEP LAB	0.153135	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.329300	2,725,842	897,620	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.347483	2,643,295	918,500	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.113210	40,479	4,583	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.236033	7,213	1,703	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.522731	509,031	266,086	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.501270	2,236	1,121	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.326368	693,391	226,301	73.00
74.00	07400	RENAL DIALYSIS	0.310114	251,823	78,094	74.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000	CLINIC	1.159737	0	0	90.00
90.01	09001	HOMER GLEN LAB	0.000000	0	0	90.01
90.02	09002	HOMER GLEN FEC	0.000000	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0.000000	0	0	90.03
91.00	09100	EMERGENCY	0.198263	416	82	91.00
91.01	09101	OP MENTAL HEALTH	0.482922	0	0	91.01
91.02	09102	DIABETES CENTER	1.208979	1,855	2,243	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.829010	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
94.00	09400	HOME PROGRAM DIALYSIS	0.000000	0	0	94.00
200.00		Total (sum of lines 50-94 and 96-98)		9,085,260	2,652,579	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)		9,085,260		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0213	Period: From 10/01/2015 To 09/30/2016	Worksheet E Part A Date/Time Prepared: 2/27/2017 8:38 am
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	55,225,491	1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)	0	1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)	0	1.04
2.00	Outlier payments for discharges. (see instructions)	1,164,428	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	11,045,197	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	227.22	4.00
	Indirect Medical Education Adjustment		
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996.(see instructions)	0.00	5.00
6.00	FTE count for allopathic and osteopathic programs 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), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA		
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
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	2.15	30.00
31.00	Percentage of Medicaid patient days (see instructions)	15.92	31.00
32.00	Sum of lines 30 and 31	18.07	32.00
33.00	Allowable disproportionate share percentage (see instructions)	4.50	33.00
34.00	Disproportionate share adjustment (see instructions)	621,287	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0213	Period: From 10/01/2015 To 09/30/2016	Worksheet E Part A Date/Time Prepared: 2/27/2017 8:38 am
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		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	0	6,406,145,534	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000273372	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	0	1,751,259	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	0	1,751,259	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,751,259		36.00
	Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)			
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)	0		40.00
		Before 1/1	On/After 1/1	
		1.00	1.01	
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)	0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)	0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)	0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)	0		46.00
47.00	Subtotal (see instructions)	58,762,465		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only.(see instructions)	0		48.00
			Amount	
			1.00	
49.00	Total payment for inpatient operating costs (see instructions)		58,762,465	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		4,906,317	50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0	52.00
53.00	Nursing and Allied Health Managed Care payment		40,814	53.00
54.00	Special add-on payments for new technologies		5,524	54.00
54.01	Islet isolation add-on payment			54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		22,437	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		120,121	58.00
59.00	Total (sum of amounts on lines 49 through 58)		63,857,678	59.00
60.00	Primary payer payments		30,392	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		63,827,286	61.00
62.00	Deductibles billed to program beneficiaries		6,188,420	62.00
63.00	Coinsurance billed to program beneficiaries		205,961	63.00
64.00	Allowable bad debts (see instructions)		770,342	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		500,722	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		400,762	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		57,933,627	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.50	RURAL DEMONSTRATION PROJECT		0	70.50
70.88	SCH or MDH volume decrease adjustment		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0	70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0	70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0	70.91
70.92	Bundled Model 1 discount amount (see instructions)		0	70.92
70.93	HVBP payment adjustment amount (see instructions)		362,141	70.93
70.94	HRR adjustment amount (see instructions)		-955,495	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0213	Period: From 10/01/2015 To 09/30/2016	Worksheet E Part A Date/Time Prepared: 2/27/2017 8:38 am
	Title XVIII	Hospital	PPS

		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		57,340,273	71.00
71.01	Sequestration adjustment (see instructions)		1,146,805	71.01
72.00	Interim payments		56,081,833	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)		111,635	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		1,166,763	75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0	90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00	Time value of money for operating expenses (see instructions)		0	95.00
96.00	Time value of money for capital related expenses (see instructions)		0	96.00

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	HSP Bonus Payment Amount			
100.00	HSP bonus amount (see instructions)		0	100.00
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)		0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)		0	102.00
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)		0.0000	103.00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)		0	104.00

LOW VOLUME CALCULATION EXHIBIT 4

Provider CCN: 14-0213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 2/27/2017 8:38 am

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
1.00	DRG amounts other than outlier payments	1.00	0	0	0	0	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	0	0		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	55,225,491	0		55,225,491	55,225,491	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	1,164,428	0	0	1,164,428	1,164,428	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	11,045,197	0	0	0	0	4.00
	Indirect Medical Education Adjustment							
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA							
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	0	9.01
	Disproportionate Share Adjustment							
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0450	0.0450	0.0450	0.0450		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	621,287	0	0	621,287	621,287	11.00
11.01	Uncompensated care payments	36.00	1,751,259	0	0	1,751,259	1,751,259	11.01
	Additional payment for high percentage of ESRD beneficiary discharges							
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	58,762,465	0	0	58,762,465	58,762,465	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	58,762,465	0	0	58,762,465	58,762,465	15.00
16.00	Payment for inpatient program capital	50.00	4,906,317	0	0	4,906,317	4,906,317	16.00
17.00	Special add-on payments for new technologies	54.00	5,524	0	0	5,524	5,524	17.00
17.01	Net organ aquisition cost	55.00	0	0	0	0	0	17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	0	18.00

LOW VOLUME CALCULATION EXHIBIT 4 | Provider CCN: 14-0213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet E Part A Exhibit 4 Date/Time Prepared: 2/27/2017 8:38 am

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		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4.00	5.00	
19.00	SUBTOTAL			0	0	63,674,306	63,674,306	19.00
		W/S L, line	(Amounts from L)					
		0	1.00	2.00	3.00	4.00	5.00	
20.00	Capital DRG other than outlier	1.00	4,429,783	0	0	4,429,783	4,429,783	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	311,303	0	0	311,303	311,303	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0373	0.0373	0.0373	0.0373		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	165,231	0	0	165,231	165,231	25.00
26.00	Total prospective capital payments (see instructions)	12.00	4,906,317	0	0	4,906,317	4,906,317	26.00
		W/S E, Part A line	(Amounts to E, Part A)					
		0	1.00	2.00	3.00	4.00	5.00	
27.00	Low volume adjustment factor				0.000000	0.000000		27.00
28.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.96			0		0	28.00
29.00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70.97				0	0	29.00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 14-0213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 2/27/2017 8:38 am

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		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	0	0		0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	55,225,491		55,225,491	55,225,491	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0	0		0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1.04
2.00	Outlier payments for discharges (see instructions)	2.00	1,164,428	0	1,164,428	1,164,428	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0	0	0	0	2.01
3.00	Operating outlier reconciliation	2.01	0	0	0	0	3.00
4.00	Managed care simulated payments	3.00	11,045,197	0	0	0	4.00
	Indirect Medical Education Adjustment						
5.00	Amount from Worksheet E, Part A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000		5.00
6.00	IME payment adjustment (see instructions)	22.00	0	0	0	0	6.00
6.01	IME payment adjustment for managed care (see instructions)	22.01	0	0	0	0	6.01
	Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA						
7.00	IME payment adjustment factor (see instructions)	27.00	0.000000	0.000000	0.000000		7.00
8.00	IME adjustment (see instructions)	28.00	0	0	0	0	8.00
8.01	IME payment adjustment add on for managed care (see instructions)	28.01	0	0	0	0	8.01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0	0	0	0	9.00
9.01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	0	0	9.01
	Disproportionate Share Adjustment						
10.00	Allowable disproportionate share percentage (see instructions)	33.00	0.0450	0.0450	0.0450		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	621,287	0	621,287	621,287	11.00
11.01	Uncompensated care payments	36.00	1,751,259	0	0	0	11.01
	Additional payment for high percentage of ESRD beneficiary discharges						
12.00	Total ESRD additional payment (see instructions)	46.00	0	0	0	0	12.00
13.00	Subtotal (see instructions)	47.00	58,762,465	0	58,762,465	58,762,465	13.00
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0	0	0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	58,762,465	0	58,762,465	58,762,465	15.00
16.00	Payment for inpatient program capital	50.00	4,906,317	0	4,906,317	4,906,317	16.00
17.00	Special add-on payments for new technologies	54.00	5,524	0	5,524	5,524	17.00
17.01	Net organ acquisition cost	55.00	0	0	0	0	17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			0	63,674,306	63,674,306	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 14-0213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 2/27/2017 8:38 am

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		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	4,429,783	0	4,429,783	4,429,783	20.00
20.01	Model 4 BPCI Capital DRG other than outlier	1.01	0	0	0	0	20.01
21.00	Capital DRG outlier payments	2.00	311,303	0	311,303	311,303	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0	0	0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.0000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0	0	0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0.0373	0.0373	0.0373		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	165,231	0	165,231	165,231	25.00
26.00	Total prospective capital payments (see instructions)	12.00	4,906,317	0	4,906,317	4,906,317	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0	0		0	28.00
29.00	Low volume adjustment on or after October 1	70.97	0		0	0	29.00
30.00	HVBP payment adjustment (see instructions)	70.93	362,141	0	362,141	362,141	30.00
30.01	HVBP payment adjustment for HSP bonus payment (see instructions)	70.90	0	0	0	0	30.01
31.00	HRR adjustment (see instructions)	70.94	-955,495	0	-955,495	-955,495	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70.91	0	0	0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
		0	1.00	2.00	3.00	4.00	
32.00	HAC Reduction Program adjustment (see instructions)	70.99		0	0	0	32.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0213	Period: From 10/01/2015 To 09/30/2016	Worksheet E Part B Date/Time Prepared: 2/27/2017 8:38 am
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		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	57,279	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	27,793,791	2.00
3.00	PPS payments	25,025,593	3.00
4.00	Outlier payment (see instructions)	88,528	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	86,203	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	57,279	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	134,732	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)	134,732	14.00
	Customary charges		
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0.000000	17.00
18.00	Total customary charges (see instructions)	134,732	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	77,453	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)	57,279	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)	25,200,324	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	17,239	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	5,045,437	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)	20,194,927	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	0	29.00
30.00	Subtotal (sum of lines 27 through 29)	20,194,927	30.00
31.00	Primary payer payments	3,406	31.00
32.00	Subtotal (line 30 minus line 31)	20,191,521	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
34.00	Allowable bad debts (see instructions)	484,038	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	314,625	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	300,550	36.00
37.00	Subtotal (see instructions)	20,506,146	37.00
38.00	MSP-LCC reconciliation amount from PS&R	-9	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	20,506,155	40.00
40.01	Sequestration adjustment (see instructions)	410,123	40.01
41.00	Interim payments	19,962,045	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	133,987	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	433,134	44.00
	TO BE COMPLETED BY CONTRACTOR		
90.00	Original outlier amount (see instructions)	0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)	0	91.00
92.00	The rate used to calculate the Time Value of Money	0.00	92.00
93.00	Time Value of Money (see instructions)	0	93.00
94.00	Total (sum of lines 91 and 93)	0	94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet E-1 Part I | Date/Time Prepared: 2/27/2017 8:38 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		56,209,684		20,057,841	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM	04/26/2016	58,863	04/26/2016	95,796	3.50
3.51		09/20/2016	68,988		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)		-127,851		-95,796	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)		56,081,833		19,962,045	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		111,635		133,987	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		56,193,468		20,096,032	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0213 | Component CCN: 14-S213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet E-1 Part I | Date/Time Prepared: 2/27/2017 8:38 am

Title XVIII | Subprovider - IPF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		1,034,993		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,034,993		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		50,618		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,085,611		0	7.00

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

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 14-0213 | Component CCN: 14-T213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet E-1 Part I | Date/Time Prepared: 2/27/2017 8:38 am

Title XVIII | Subprovider - IRF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		8,049,512		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		8,049,512		0	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		38,968		0	6.02
7.00	Total Medicare program liability (see instructions)		8,010,544		0	7.00

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

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 14-0213	Period: From 10/01/2015 To 09/30/2016	Worksheet E-1 Part II Date/Time Prepared: 2/27/2017 8:38 am
	Title XVIII	Hospital	PPS

		1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION		
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14	18,807	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12	29,983	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	6,077	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12	64,785	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	1,206,608,417	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20	14,899,455	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)	779,403	8.00
9.00	Sequestration adjustment amount (see instructions)	15,588	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)	763,815	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH		
30.00	Initial/interim HIT payment adjustment (see instructions)	0	30.00
31.00	Other Adjustment (specify)	0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)	763,815	32.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0213 Component CCN: 14-S213	Period: From 10/01/2015 To 09/30/2016	Worksheet E-3 Part II Date/Time Prepared: 2/27/2017 8:38 am
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS		
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	1,235,892	1.00
2.00	Net IPF PPS Outlier Payments	419	2.00
3.00	Net IPF PPS ECT Payments	0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)	0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	4.01
5.00	New Teaching program adjustment. (see instructions)	0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instuctions)	0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instuctions)	0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.00	8.00
9.00	Average Daily Census (see instructions)	16.969945	9.00
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).	0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	1,236,311	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)	1,236,311	16.00
17.00	Primary payer payments	6,716	17.00
18.00	Subtotal (line 16 less line 17).	1,229,595	18.00
19.00	Deductibles	142,100	19.00
20.00	Subtotal (line 18 minus line 19)	1,087,495	20.00
21.00	Coinsurance	31,374	21.00
22.00	Subtotal (line 20 minus line 21)	1,056,121	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	66,059	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	42,938	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	53,664	25.00
26.00	Subtotal (sum of lines 22 and 24)	1,099,059	26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	27.00
28.00	Other pass through costs (see instructions)	8,707	28.00
29.00	Outlier payments reconciliation	0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	30.50
30.99	Recovery of Accelerated Depreciation	0	30.99
31.00	Total amount payable to the provider (see instructions)	1,107,766	31.00
31.01	Sequestration adjustment (see instructions)	22,155	31.01
32.00	Interim payments	1,034,993	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)	50,618	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	5,232	35.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	419	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0213 Component CCN: 14-T213	Period: From 10/01/2015 To 09/30/2016	Worksheet E-3 Part III Date/Time Prepared: 2/27/2017 8:38 am
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	7,692,732	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0082	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	66,927	3.00
4.00	Outlier Payments	505,312	4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0.00	5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	5.01
6.00	New Teaching program adjustment. (see instructions)	0.00	6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)	0.00	7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)	0.00	8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9.00
10.00	Average Daily Census (see instructions)	22.062842	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)	8,264,971	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)	0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)		15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)	0	16.00
17.00	Subtotal (see instructions)	8,264,971	17.00
18.00	Primary payer payments	0	18.00
19.00	Subtotal (line 17 less line 18).	8,264,971	19.00
20.00	Deductibles	26,852	20.00
21.00	Subtotal (line 19 minus line 20)	8,238,119	21.00
22.00	Coinsurance	67,130	22.00
23.00	Subtotal (line 21 minus line 22)	8,170,989	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	3,808	24.00
25.00	Adjusted reimbursable bad debts (see instructions)	2,475	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	2,548	26.00
27.00	Subtotal (sum of lines 23 and 25)	8,173,464	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28.00
29.00	Other pass through costs (see instructions)	560	29.00
30.00	Outlier payments reconciliation	0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	31.50
31.99	Recovery of Accelerated Depreciation	0	31.99
32.00	Total amount payable to the provider (see instructions)	8,174,024	32.00
32.01	Sequestration adjustment (see instructions)	163,480	32.01
33.00	Interim payments	8,049,512	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)	-38,968	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	248	36.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	505,312	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) | Provider CCN: 14-0213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet G | Date/Time Prepared: 2/27/2017 8:38 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	44,641,000	0	0	0	1.00
2.00	Temporary investments	2,358,000	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	44,586,000	0	0	0	4.00
5.00	Other receivable	1,181,000	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	4,005,000	0	0	0	8.00
9.00	Other current assets	368,000	0	0	0	9.00
10.00	Due from other funds	35,010,000	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	132,149,000	0	0	0	11.00
	FIXED ASSETS					
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	606,486,918	0	0	0	15.00
16.00	Accumulated depreciation	-189,130,918	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)	417,356,000	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	149,879,000	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	36,944,000	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	186,823,000	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	736,328,000	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	20,323,000	0	0	0	37.00
38.00	Salaries, wages, and fees payable	16,235,000	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	7,115,000	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	41,103,000	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	84,776,000	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	411,531,000	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	6,542,000	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	418,073,000	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	502,849,000	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	233,479,000				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	233,479,000	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	736,328,000	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-0213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet G-1 | Date/Time Prepared: 2/27/2017 8:38 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		207,448,000		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		25,059,249				2.00
3.00	Total (sum of line 1 and line 2)		232,507,249		0		3.00
4.00	INCREASE IN TEMPORARILY RESTRICTED A	383,000		0		0	4.00
5.00	PERMANENTLY RESTRICED ASSETS	277,000		0		0	5.00
6.00	INCREASE UNRESTRICTED ASSETS	311,751		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		971,751		0		10.00
11.00	Subtotal (line 3 plus line 10)		233,479,000		0		11.00
12.00	Deductions (debit adjustments) (specify)	0		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		233,479,000		0		19.00

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES | Provider CCN: 14-0213 | Period: From 10/01/2015 To 09/30/2016 | Worksheet G-2 Parts I & II Date/Time Prepared: 2/27/2017 8:38 am

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	65,444,032		65,444,032	1.00
2.00	SUBPROVIDER - IPF	6,991,757		6,991,757	2.00
3.00	SUBPROVIDER - IRF	16,789,294		16,789,294	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)	89,225,083		89,225,083	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	19,065,027		19,065,027	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	19,065,027		19,065,027	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	108,290,110		108,290,110	17.00
18.00	Ancillary services	408,663,047	546,031,905	954,694,952	18.00
19.00	Outpatient services	29,769,111	82,672,118	112,441,229	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		6,334,138	6,334,138	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	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	546,722,268	635,038,161	1,181,760,429	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		345,666,457		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)		345,666,457		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 14-0213	Period: From 10/01/2015 To 09/30/2016	Worksheet G-3 Date/Time Prepared: 2/27/2017 8:38 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	1,181,760,429	1.00
2.00	Less contractual allowances and discounts on patients' accounts	820,997,723	2.00
3.00	Net patient revenues (line 1 minus line 2)	360,762,706	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	345,666,457	4.00
5.00	Net income from service to patients (line 3 minus line 4)	15,096,249	5.00
	OTHER INCOME		
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISC - OTHER REVENUE	8,429,000	24.00
24.01	NON-OPERATING INCOME	1,534,000	24.01
25.00	Total other income (sum of lines 6-24)	9,963,000	25.00
26.00	Total (line 5 plus line 25)	25,059,249	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)	25,059,249	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 14-0213 | HHA CCN: 14-7452 | Period: From 10/01/2015 To 09/30/2016 | Worksheet H | Date/Time Prepared: 2/27/2017 8:38 am

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		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	535,423	0	0	2,939	95,302	633,664	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	191,309	191,309	6.00
7.00	Physical Therapy	0	0	0	1,060,992	0	1,060,992	7.00
8.00	Occupational Therapy	0	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	1,299,654	0	0	0	0	1,299,654	10.00
11.00	Home Health Aide	48,852	0	8,699	0	0	57,551	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	1,883,929	0	8,699	1,063,931	286,611	3,243,170	24.00

		Reclassification	Reclassified Trial Balance (col. 6 + col.7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
		7.00	8.00	9.00	10.00			
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0	0	0			1.00
2.00	Capital Related - Movable Equipment	0	0	0	0			2.00
3.00	Plant Operation & Maintenance	0	0	0	0			3.00
4.00	Transportation	0	0	0	0			4.00
5.00	Administrative and General	35,000	668,664	0	668,664			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	191,309	0	191,309			6.00
7.00	Physical Therapy	-59,467	1,001,525	0	1,001,525			7.00
8.00	Occupational Therapy	0	0	0	0			8.00
9.00	Speech Pathology	0	0	0	0			9.00
10.00	Medical Social Services	0	1,299,654	0	1,299,654			10.00
11.00	Home Health Aide	0	57,551	0	57,551			11.00
12.00	Supplies (see instructions)	0	0	0	0			12.00
13.00	Drugs	0	0	0	0			13.00
14.00	DME	0	0	0	0			14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0			15.00
16.00	Respiratory Therapy	0	0	0	0			16.00
17.00	Private Duty Nursing	0	0	0	0			17.00
18.00	Clinic	0	0	0	0			18.00
19.00	Health Promotion Activities	0	0	0	0			19.00
20.00	Day Care Program	0	0	0	0			20.00
21.00	Home Delivered Meals Program	0	0	0	0			21.00
22.00	Homemaker Service	0	0	0	0			22.00
23.00	All Others (specify)	0	0	0	0			23.00
23.50	Telemedicine	0	0	0	0			23.50
24.00	Total (sum of lines 1-23)	-24,467	3,218,703	0	3,218,703			24.00

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

COST ALLOCATION - HHA GENERAL SERVICE COST | Provider CCN: 14-0213 | HHA CCN: 14-7452 | Period: From 10/01/2015 To 09/30/2016 | Worksheet H-1 Part I | Date/Time Prepared: 2/27/2017 8:38 am

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		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs: Bldgs & Fixtures	Capital Related Costs: Movable Equipment	Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)	
		0	1.00	2.00	3.00	4.00	4A.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0	0				0	1.00
2.00	Capital Related - Movable Equipment	0		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0		0	3.00
4.00	Transportation	0	0	0	0	0		4.00
5.00	Administrative and General	668,664	0	0	0	0	668,664	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	191,309	0	0	0	0	191,309	6.00
7.00	Physical Therapy	1,001,525	0	0	0	0	1,001,525	7.00
8.00	Occupational Therapy	0	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	1,299,654	0	0	0	0	1,299,654	10.00
11.00	Home Health Aide	57,551	0	0	0	0	57,551	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0		0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	3,218,703	0	0	0	0	3,218,703	24.00

		Administrative & General	Total (cols. 4A + 5)		
		5.00	6.00		
	GENERAL SERVICE COST CENTERS				
1.00	Capital Related - Bldg. & Fixtures				1.00
2.00	Capital Related - Movable Equipment				2.00
3.00	Plant Operation & Maintenance				3.00
4.00	Transportation				4.00
5.00	Administrative and General	668,664			5.00
	HHA REIMBURSABLE SERVICES				
6.00	Skilled Nursing Care	50,164	241,473		6.00
7.00	Physical Therapy	262,617	1,264,142		7.00
8.00	Occupational Therapy	0	0		8.00
9.00	Speech Pathology	0	0		9.00
10.00	Medical Social Services	340,792	1,640,446		10.00
11.00	Home Health Aide	15,091	72,642		11.00
12.00	Supplies (see instructions)	0	0		12.00
13.00	Drugs	0	0		13.00
14.00	DME	0	0		14.00
	HHA NONREIMBURSABLE SERVICES				
15.00	Home Dialysis Aide Services	0	0		15.00
16.00	Respiratory Therapy	0	0		16.00
17.00	Private Duty Nursing	0	0		17.00
18.00	Clinic	0	0		18.00
19.00	Health Promotion Activities	0	0		19.00
20.00	Day Care Program	0	0		20.00
21.00	Home Delivered Meals Program	0	0		21.00
22.00	Homemaker Service	0	0		22.00
23.00	All Others (specify)	0	0		23.00
23.50	Telemedicine	0	0		23.50
24.00	Total (sum of lines 1-23)		3,218,703		24.00

COST ALLOCATION - HHA STATISTICAL BASIS

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

Period: From 10/01/2015 To 09/30/2016

Worksheet H-1 Part II
Date/Time Prepared: 2/27/2017 8:38 am

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		Capital Related Costs						
		Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
		1.00	2.00	3.00	4.00	5A.00	5.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0				0		1.00
2.00	Capital Related - Movable Equipment		0			0		2.00
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see instructions)	0	0	0	0			4.00
5.00	Administrative and General	0	0	0	0	-668,664	2,550,039	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	191,309	6.00
7.00	Physical Therapy	0	0	0	0	0	1,001,525	7.00
8.00	Occupational Therapy	0	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	1,299,654	10.00
11.00	Home Health Aide	0	0	0	0	0	57,551	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	0	12.00
13.00	Drugs	0	0	0		0	0	13.00
14.00	DME	0	0	0	0	0	0	14.00
	HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	0	23.00
23.50	Telemedicine	0	0	0	0	0	0	23.50
24.00	Total (sum of lines 1-23)	0	0	0	0	-668,664	2,550,039	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		668,664	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.262217	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0213 | HHA CCN: 14-7452 | Period: From 10/01/2015 To 09/30/2016 | Worksheet H-2 Part I | Date/Time Prepared: 2/27/2017 8:38 am

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	Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		0	1.00	2.00	4.00	4A	5.00	
1.00	Administrative and General	0	0	1,332	551,392	552,724	144,094	1.00
2.00	Skilled Nursing Care	241,473	0	0	0	241,473	62,952	2.00
3.00	Physical Therapy	1,264,142	0	0	0	1,264,142	329,559	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	1,640,446	0	0	0	1,640,446	427,660	6.00
7.00	Home Health Aide	72,642	0	0	0	72,642	18,938	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	3,218,703	0	1,332	551,392	3,771,427	983,203	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	293,081	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	0	0	0	0	0	293,081	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 14-0213 | HHA CCN: 14-7452 | Period: From 10/01/2015 To 09/30/2016 | Worksheet H-2 Part I | Date/Time Prepared: 2/27/2017 8:38 am

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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	8,986	1,163	0	0	0	1,000,048	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	304,425	2.00
3.00	Physical Therapy	0	0	0	0	0	1,593,701	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	2,068,106	6.00
7.00	Home Health Aide	0	0	0	0	0	91,580	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19) (2)	8,986	1,163	0	0	0	5,057,860	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	1,000,048					1.00
2.00	Skilled Nursing Care	0	304,425	75,026	379,451			2.00
3.00	Physical Therapy	0	1,593,701	392,768	1,986,469			3.00
4.00	Occupational Therapy	0	0	0	0			4.00
5.00	Speech Pathology	0	0	0	0			5.00
6.00	Medical Social Services	0	2,068,106	509,684	2,577,790			6.00
7.00	Home Health Aide	0	91,580	22,570	114,150			7.00
8.00	Supplies (see instructions)	0	0	0	0			8.00
9.00	Drugs	0	0	0	0			9.00
10.00	DME	0	0	0	0			10.00
11.00	Home Dialysis Aide Services	0	0	0	0			11.00
12.00	Respiratory Therapy	0	0	0	0			12.00
13.00	Private Duty Nursing	0	0	0	0			13.00
14.00	Clinic	0	0	0	0			14.00
15.00	Health Promotion Activities	0	0	0	0			15.00
16.00	Day Care Program	0	0	0	0			16.00
17.00	Home Delivered Meals Program	0	0	0	0			17.00
18.00	Homemaker Service	0	0	0	0			18.00
19.00	All Others (specify)	0	0	0	0			19.00
19.50	Telemedicine	0	0	0	0			19.50
20.00	Total (sum of lines 1-19) (2)	0	5,057,860	1,000,048	5,057,860			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.			0.246450				21.00

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

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

Period: From 10/01/2015 To 09/30/2016

Worksheet H-2 Part II Date/Time Prepared: 2/27/2017 8:38 am

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	Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
		1.00	2.00	4.00	5A	5.00	7.00	
1.00	Administrative and General	0	1,193	1,883,929	0	552,724	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	241,473	0	2.00
3.00	Physical Therapy	0	0	0	0	1,264,142	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	1,640,446	0	6.00
7.00	Home Health Aide	0	0	0	0	72,642	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	1,193	1,883,929		3,771,427	0	20.00
21.00	Total cost to be allocated	0	1,332	551,392		983,203	0	21.00
22.00	Unit cost multiplier	0.000000	1.116513	0.292682		0.260698	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 NRS ING)	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	49,088	73,787	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
19.50	Telemedicine	0	0	0	0	0	0	19.50
20.00	Total (sum of lines 1-19)	0	0	0	0	49,088	73,787	20.00
21.00	Total cost to be allocated	0	0	0	0	293,081	8,986	21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.000000	0.000000	5.970522	0.121783	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

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

Period: From 10/01/2015 To 09/30/2016

Worksheet H-2 Part II
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	Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	PARAMED ED PRGM (ASSIGNED TIME)			
		15.00	16.00	17.00	23.00			
1.00	Administrative and General	1,609	0	0	0			1.00
2.00	Skilled Nursing Care	0	0	0	0			2.00
3.00	Physical Therapy	0	0	0	0			3.00
4.00	Occupational Therapy	0	0	0	0			4.00
5.00	Speech Pathology	0	0	0	0			5.00
6.00	Medical Social Services	0	0	0	0			6.00
7.00	Home Health Aide	0	0	0	0			7.00
8.00	Supplies (see instructions)	0	0	0	0			8.00
9.00	Drugs	0	0	0	0			9.00
10.00	DME	0	0	0	0			10.00
11.00	Home Dialysis Aide Services	0	0	0	0			11.00
12.00	Respiratory Therapy	0	0	0	0			12.00
13.00	Private Duty Nursing	0	0	0	0			13.00
14.00	Clinic	0	0	0	0			14.00
15.00	Health Promotion Activities	0	0	0	0			15.00
16.00	Day Care Program	0	0	0	0			16.00
17.00	Home Delivered Meals Program	0	0	0	0			17.00
18.00	Homemaker Service	0	0	0	0			18.00
19.00	All Others (specify)	0	0	0	0			19.00
19.50	Telemedicine	0	0	0	0			19.50
20.00	Total (sum of lines 1-19)	1,609	0	0	0			20.00
21.00	Total cost to be allocated	1,163	0	0	0			21.00
22.00	Unit cost multiplier	0.722809	0.000000	0.000000	0.000000			22.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0213 | HHA CCN: 14-7452 | Period: From 10/01/2015 To 09/30/2016 | Worksheet H-3 Part I | Date/Time Prepared: 2/27/2017 8:38 am

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	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	379,451		379,451	14,025	27.06	1.00
2.00	Physical Therapy	3.00	1,986,469	0	1,986,469	8,931	222.42	2.00
3.00	Occupational Therapy	4.00	0	0	0	2,579	0.00	3.00
4.00	Speech Pathology	5.00	0	0	0	310	0.00	4.00
5.00	Medical Social Services	6.00	2,577,790		2,577,790	78	33,048.59	5.00
6.00	Home Health Aide	7.00	114,150		114,150	1,431	79.77	6.00
7.00	Total (sum of lines 1-6)		5,057,860	0	5,057,860	27,354		7.00

	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles		
		0	1.00	2.00	3.00	4.00	5.00	
	Limitation Cost Computation							
8.00	Skilled Nursing Care		16974	0	9,779			8.00
9.00	Physical Therapy		16974	0	5,593			9.00
10.00	Occupational Therapy		16974	0	1,767			10.00
11.00	Speech Pathology		16974	0	206			11.00
12.00	Medical Social Services		16974	0	50			12.00
13.00	Home Health Aide		16974	0	1,223			13.00
14.00	Total (sum of lines 8-13)			0	18,618			14.00

	Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (cols. 1 + 2)	Total Charges (from HHA Records)	Ratio (col. 3 ÷ col. 4)	
		0	1.00	2.00	3.00	4.00	5.00	
	Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	0	0	0	0	0.000000	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	0.000000	16.00

	Cost Center Description	Program Visits Part A	Program Visits Part B Not Subject to Deductibles & Coinsurance	Program Visits Part B Subject to Deductibles & Coinsurance	Cost of Services Part A	Part B Not Subject to Deductibles & Coinsurance	Part B Subject to Deductibles & Coinsurance	
		6.00	7.00	8.00	9.00	10.00	11.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	9,779		0	264,620		1.00
2.00	Physical Therapy	0	5,593		0	1,243,995		2.00
3.00	Occupational Therapy	0	1,767		0	0		3.00
4.00	Speech Pathology	0	206		0	0		4.00
5.00	Medical Social Services	0	50		0	1,652,430		5.00
6.00	Home Health Aide	0	1,223		0	97,559		6.00
7.00	Total (sum of lines 1-6)	0	18,618		0	3,258,604		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: 14-0213 | HHA CCN: 14-7452 | Period: From 10/01/2015 To 09/30/2016 | Worksheet H-3 Part I | Date/Time Prepared: 2/27/2017 8:38 am

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

	Cost Center Description	Total Program Cost (sum of cols. 9-10)	
		12.00	
	PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION		
	Cost Per Visit Computation		
1.00	Skilled Nursing Care	264,620	1.00
2.00	Physical Therapy	1,243,995	2.00
3.00	Occupational Therapy	0	3.00
4.00	Speech Pathology	0	4.00
5.00	Medical Social Services	1,652,430	5.00
6.00	Home Health Aide	97,559	6.00
7.00	Total (sum of lines 1-6)	3,258,604	7.00

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

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0213 | HHA CCN: 14-7452 | Period: From 10/01/2015 To 09/30/2016 | Worksheet H-3 Part II | Date/Time Prepared: 2/27/2017 8:38 am

Title XVIII | Home Health Agency I | PPS

	Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
		0	1.00	2.00	3.00	4.00		
	PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy	66.00	0.329300	0	0	col. 2, line 2.00		1.00
2.00	Occupational Therapy	67.00	0.347483	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	0.522731	0	0	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.326368	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0213 | HHA CCN: 14-7452 | Period: From 10/01/2015 To 09/30/2016 | Worksheet H-4 Part I-II | Date/Time Prepared: 2/27/2017 8:38 am

Title XVIII | Home Health Agency I | PPS

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

		Part A Services	Part B Services	
		1.00	2.00	
	PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			
10.00	Total reasonable cost (see instructions)	0	0	10.00
11.00	Total PPS Reimbursement - Full Episodes without Outliers	0	2,745,519	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	125,599	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	35,065	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	103,939	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	16,151	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	8,554	16.00
17.00	Total Other Payments	0	0	17.00
18.00	DME Payments	0	0	18.00
19.00	Oxygen Payments	0	0	19.00
20.00	Prosthetic and Orthotic Payments	0	0	20.00
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	21.00
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)	0	3,034,827	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	3,034,827	24.00
25.00	Coinsurance billed to program patients (from your records)		0	25.00
26.00	Net cost (line 24 minus line 25)	0	3,034,827	26.00
27.00	Reimbursable bad debts (from your records)			27.00
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			28.00
29.00	Total costs - current cost reporting period (line 26 plus line 27)	0	3,034,827	29.00
30.00	OTHER ADJUSTMENTS	0	-3,710	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	30.50
31.00	Subtotal (see instructions)	0	3,031,117	31.00
31.01	Sequestration adjustment (see instructions)	0	60,622	31.01
32.00	Interim payments (see instructions)	0	2,970,495	32.00
33.00	Tentative settlement (for contractor use only)	0	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)	0	0	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	0	35.00

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

Provider CCN: 14-0213 | HHA CCN: 14-7452 | Period: From 10/01/2015 To 09/30/2016 | Worksheet H-5 | Date/Time Prepared: 2/27/2017 8:38 am

Home Health Agency I | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		2,970,495	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
3.01			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
	Provider to Program					
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		2,970,495	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
	Program to Provider					
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
	Provider to Program					
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		2,970,495	7.00

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

CALCULATION OF CAPITAL PAYMENT	Provider CCN: 14-0213	Period: From 10/01/2015 To 09/30/2016	Worksheet L Parts I-III Date/Time Prepared: 2/27/2017 8:38 am
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	4,429,783	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	311,303	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)	181.83	3.00
4.00	Number of interns & residents (see instructions)	0.00	4.00
5.00	Indirect medical education percentage (see instructions)	0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)	0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)	2.15	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	15.92	8.00
9.00	Sum of lines 7 and 8	18.07	9.00
10.00	Allowable disproportionate share percentage (see instructions)	3.73	10.00
11.00	Disproportionate share adjustment (see instructions)	165,231	11.00
12.00	Total prospective capital payments (see instructions)	4,906,317	12.00
		1.00	
	PART II - PAYMENT UNDER REASONABLE COST		
1.00	Program inpatient routine capital cost (see instructions)	0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)	0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)	0	3.00
4.00	Capital cost payment factor (see instructions)	0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)	0	5.00
		1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS		
1.00	Program inpatient capital costs (see instructions)	0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)	0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)	0	3.00
4.00	Applicable exception percentage (see instructions)	0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)	0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)	0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)	0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)	0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)	0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)	0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)	0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)	0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)	0	14.00
15.00	Current year allowable operating and capital payment (see instructions)	0	15.00
16.00	Current year operating and capital costs (see instructions)	0	16.00
17.00	Current year exception offset amount (see instructions)	0	17.00