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 10/01/2016 To 09/30/2017	Worksheet S Parts I-III Date/Time Prepared: 2/26/2018 4:08 pm

PART I - COST REPORT STATUS

Provider use only

1. [X] Electronically filed cost report — Date: 2/26/2018 Time: 4:08 pm
2. [ ] Manually submitted cost report
3. [0] If this is an amended report enter the number of times the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low.

Contractor use only

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

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by SILVER CROSS HOSPITAL (14-0213) for the cost reporting period beginning 10/01/2016 and ending 09/30/2017 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

[ ] I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature.

(Signed)_____
Officer or Administrator of Provider(s)

_____
Title

_____
Date

	Cost Center Description	Title V	Title XVIII Part A	Title XVIII Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospital	0	125,715	198,435	0	0	1.00
2.00	Subprovider - IPF	0	86,039	0		0	2.00
3.00	Subprovider - IRF	0	-12,889	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	198,865	198,435	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-0213	Period: From 10/01/2016 To 09/30/2017	Worksheet S-2 Part I Date/Time Prepared: 2/26/2018 3:14 pm

	1.00	2.00	3.00	4.00	
	Hospital and Hospital Health Care Complex Address:				
1.00	Street: 1900 SILVER CROSS BLVD.	PO Box:			1.00
2.00	City: NEW LENOX	State: IL	Zip Code: 60451	County: WILL	2.00

		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)			
							V	XVIII	XIX	
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component Identification:									
3.00	Hospital	SILVER CROSS HOSPITAL	140213	16974	1	07/01/1966	N	P	P	3.00
4.00	Subprovider - IPF	SCH - MENTAL HEALTH CARE UNIT	14S213	16974	4	04/01/1991	N	P	P	4.00
5.00	Subprovider - IRF	SCH - REHAB	14T213	16974	5	10/01/2000	N	P	P	5.00
6.00	Subprovider - (Other)									6.00
7.00	Swing Beds - SNF									7.00
8.00	Swing Beds - NF									8.00
9.00	Hospital-Based SNF									9.00
10.00	Hospital-Based NF									10.00
11.00	Hospital-Based OLTC									11.00
12.00	Hospital-Based HHA	SCH HOME HEALTH	147452	16974		04/01/1994	N	P	N	12.00
13.00	Separately Certified ASC									13.00
14.00	Hospital-Based Hospice									14.00
15.00	Hospital-Based Health Clinic - RHC									15.00
16.00	Hospital-Based Health Clinic - FQHC									16.00
17.00	Hospital-Based (CMHC) I									17.00
17.10	Hospital-Based (CORF) I									17.10
18.00	Renal Dialysis									18.00
18.01										18.01
18.02										18.02
19.00	Other									19.00

		From:	To:	
		1.00	2.00	
20.00	Cost Reporting Period (mm/dd/yyyy)	10/01/2016	09/30/2017	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.	2,719	3,108	0	0	5,377	0	24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0213 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part I | Date/Time Prepared: 2/26/2018 3:14 pm

		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
		1.00	2.00	3.00	4.00	5.00	6.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	101	0	0	48		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)(i) or (ii)? Enter in column 1 “Y” for yes or “N” for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i) or (ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)	N	N	39.00
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)	N	N	40.00

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

		NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
		1.00	2.00	3.00	
60.00	Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)	Y			60.00
60.01	If line 60 is yes, complete columns 2 and 3 for each program. (see instructions)		23.00	1	60.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0213 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part I | Date/Time Prepared: 2/26/2018 3:14 pm

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0213 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part I | Date/Time Prepared: 2/26/2018 3:14 pm

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

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

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

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

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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
98.00	Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.00
98.01	Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.01
98.02	Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.02
98.03	Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.03
98.04	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.04
98.05	Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.05
98.06	Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	Y	Y	98.06
	Rural Providers			
105.00	Does this hospital qualify as a CAH?	N		105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	N		107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.00

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 14-0213	Period: From 10/01/2016 To 09/30/2017	Worksheet S-2 Part I Date/Time Prepared: 2/26/2018 3:14 pm

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

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

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

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA | Provider CCN: 14-0213 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-2 Part I | Date/Time Prepared: 2/26/2018 3:14 pm

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

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

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

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

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

		1.00	
	Multicampus		
165.00	Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.	N	165.00

		Name	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00

		1.00	
	Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act		
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.	Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0	168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)		168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	9.99	169.00

		Beginning	Ending	
		1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	10/01/2015	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 10/01/2016 To 09/30/2017 | Worksheet S-2 Part II | Date/Time Prepared: 2/26/2018 3:14 pm

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

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

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

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

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

		Part A		Part B		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	02/20/2018	Y	02/20/2018	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 10/01/2016 To 09/30/2017 | Worksheet S-2 Part II Date/Time Prepared: 2/26/2018 3:14 pm

		Description		Y/N	Y/N	
		0		1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
	Capital Related Cost					
22.00	Have assets been relifed for Medicare purposes? If yes, see instructions				N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				N	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				N	27.00
	Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				N	31.00
	Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.					33.00
	Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				N	35.00
				Y/N	Date	
				1.00	2.00	
	Home Office Costs					
36.00	Were home office costs claimed on the cost report?			Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			N		37.00
38.00	If line 36 is yes , was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N		40.00
		1.00		2.00		
	Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	VINCE		PRYOR		41.00
42.00	Enter the employer/company name of the cost report preparer.	SILVER CROSS HOSPITAL				42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	815-300-7011		VPRYOR@SILVERCROSS.ORG		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 14-0213	Period: From 10/01/2016 To 09/30/2017	Worksheet S-2 Part II Date/Time Prepared: 2/26/2018 3:14 pm

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-0213 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-3 Part I Date/Time Prepared: 2/26/2018 3:14 pm

	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P Visits / Trips Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	229	83,585	0.00	0	1.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4.00	HMO IRF Subprovider						4.00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		229	83,585	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31.00	28	10,220	0.00	0	8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		257	93,805	0.00	0	14.00
15.00	CAH visits					0	15.00
16.00	SUBPROVIDER - IPF	40.00	20	7,300		0	16.00
17.00	SUBPROVIDER - IRF	41.00	25	9,125		0	17.00
18.00	SUBPROVIDER	42.00	0	0		0	18.00
19.00	SKILLED NURSING FACILITY	44.00	0	0		0	19.00
20.00	NURSING FACILITY	45.00	0	0		0	20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	101.00				0	22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)	30.00					24.10
25.00	CMHC - CMHC	99.00				0	25.00
25.10	CMHC - CORF	99.10				0	25.10
26.00	RURAL HEALTH CLINIC	88.00				0	26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00	Total (sum of lines 14-26)		302				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-0213 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-3 Part I | Date/Time Prepared: 2/26/2018 3:14 pm

	Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
		Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	26,478	4,255	57,656			1.00
2.00	HMO and other (see instructions)	7,299	5,377				2.00
3.00	HMO IPF Subprovider	0	1,119				3.00
4.00	HMO IRF Subprovider	836	48				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)	26,478	4,255	57,656			7.00
8.00	INTENSIVE CARE UNIT	3,768	591	8,011			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		526	7,132			13.00
14.00	Total (see instructions)	30,246	5,372	72,799	0.00	1,773.00	14.00
15.00	CAH visits	0	0	0			15.00
16.00	SUBPROVIDER - IPF	1,224	816	6,051	0.00	27.40	16.00
17.00	SUBPROVIDER - IRF	5,243	101	7,859	0.00	52.10	17.00
18.00	SUBPROVIDER		0	0	0.00	0.00	18.00
19.00	SKILLED NURSING FACILITY	0	0	0	0.00	0.00	19.00
20.00	NURSING FACILITY		0	0	0.00	0.00	20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	17,457	0	24,140	0.00	23.20	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	1,875.70	27.00
28.00	Observation Bed Days		1,643	11,265			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	455	1,677			32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00	LTCH non-covered days	0					33.00
33.01	LTCH site neutral days and discharges	0					33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Provider CCN: 14-0213 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-3 Part I | Date/Time Prepared: 2/26/2018 3:14 pm

	Component	Full Time Equivalents	Discharges				
		Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	6,879	1,906	18,680	1.00
2.00	HMO and other (see instructions)			1,636	1,750		2.00
3.00	HMO IPF Subprovider				194		3.00
4.00	HMO IRF Subprovider				5		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0.00	0	6,879	1,906	18,680	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0	169	130	999	16.00
17.00	SUBPROVIDER - IRF	0.00	0	409	9	642	17.00
18.00	SUBPROVIDER	0.00	0		0	0	18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY	0.00					20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY	0.00					22.00
23.00	AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00	HOSPICE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC	0.00					25.00
25.10	CMHC - CORF	0.00					25.10
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambulance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00	LTCH non-covered days			0			33.00
33.01	LTCH site neutral days and discharges			0			33.01

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0213 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-3 Part II Date/Time Prepared: 2/26/2018 3:14 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA							
	SALARIES							
1.00	Total salaries (see instructions)	200.00	125,603,268	0	125,603,268	3,900,624.00	32.20	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)		7,871,340	0	7,871,340	227,552.00	34.59	10.00
	OTHER WAGES & RELATED COSTS							
11.00	Contract labor: Direct Patient Care		3,055,575	0	3,055,575	49,355.00	61.91	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		315,009	0	315,009	2,302.00	136.84	13.00
14.00	Home office and/or related orgainzation salaries and wage-related costs		0	0	0	0.00	0.00	14.00
14.01	Home office salaries		5,542,737	0	5,542,737	18,928.00	292.83	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)		31,912,995	0	31,912,995			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		2,133,644	0	2,133,644			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
25.50	Home office wage-related (core)		0	0	0			25.50
25.51	Related organization wage-related (core)		0	0	0			25.51
25.52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25.52
25.53	Home office & Contract Physicians Part A - Teaching - wage-related (core)		0	0	0			25.53
	OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits Department	4.00	901,562	0	901,562	23,504.00	38.36	26.00
27.00	Administrative & General	5.00	16,855,790	-358,455	16,497,335	515,944.00	31.98	27.00

HOSPITAL WAGE INDEX INFORMATION | Provider CCN: 14-0213 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-3 Part II Date/Time Prepared: 2/26/2018 3:14 pm

		Wkst. A Line Number	Amount Reported	Reclassification of Salaries (from Wkst. A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		230,037	0	230,037	2,617.00	87.90	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	2,939,818	0	2,939,818	115,856.00	25.37	30.00
31.00	Laundry & Linen Service	8.00	90,869	0	90,869	5,824.00	15.60	31.00
32.00	Housekeeping	9.00	2,427,799	0	2,427,799	166,192.00	14.61	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	2,244,312	-1,742,638	501,674	32,635.00	15.37	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	1,742,638	1,742,638	113,381.00	15.37	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	2,968,744	0	2,968,744	85,072.00	34.90	38.00
39.00	Central Services and Supply	14.00	1,628,152	-947,743	680,409	41,392.00	16.44	39.00
40.00	Pharmacy	15.00	3,322,518	0	3,322,518	70,304.00	47.26	40.00
41.00	Medical Records & Medical Records Library	16.00	2,564,042	0	2,564,042	92,560.00	27.70	41.00
42.00	Social Service	17.00	0	358,455	358,455	11,752.00	30.50	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 10/01/2016 To 09/30/2017 | Worksheet S-3 Part III Date/Time Prepared: 2/26/2018 3:14 pm

		Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)		125,833,305	0	125,833,305	3,903,241.00	32.24	1.00
2.00	Excluded area salaries (see instructions)		7,871,340	0	7,871,340	227,552.00	34.59	2.00
3.00	Subtotal salaries (line 1 minus line 2)		117,961,965	0	117,961,965	3,675,689.00	32.09	3.00
4.00	Subtotal other wages & related costs (see inst.)		8,913,321	0	8,913,321	70,585.00	126.28	4.00
5.00	Subtotal wage-related costs (see inst.)		31,912,995	0	31,912,995	0.00	27.05	5.00
6.00	Total (sum of lines 3 thru 5)		158,788,281	0	158,788,281	3,746,274.00	42.39	6.00
7.00	Total overhead cost (see instructions)		36,173,643	-947,743	35,225,900	1,277,033.00	27.58	7.00

HOSPITAL WAGE RELATED COSTS | Provider CCN: 14-0213 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-3 Part IV Date/Time Prepared: 2/26/2018 3:14 pm

		Amount Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETIREMENT COST		
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	5,257,327	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)	15,876,100	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	722,074	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	132,307	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)	878,005	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	1,573,974	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)	0	16.00
	TAXES		
17.00	FICA-Employers Portion Only	9,298,836	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unemployment Insurance	90,000	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	218,014	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	34,046,637	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 10/01/2016 To 09/30/2017 | Worksheet S-3 Part V Date/Time Prepared: 2/26/2018 3:14 pm

	Cost Center Description	Contract Labor	Benefit Cost	
		1.00	2.00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	3,055,575	34,046,637	1.00
2.00	Hospital	3,055,575	34,046,637	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 10/01/2016 To 09/30/2017 | Worksheet S-4 | Date/Time Prepared: 2/26/2018 3:14 pm

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	2,374	0	0	2,374	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	769.00	17.00	394.00	1,438.00	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	8.04	0.00	8.04	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			14.04	0.00	14.04	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			0.00	84.30	84.30	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			0.00	1.80	1.80	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.00	4.60	4.60	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.03	4.50	4.53	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			1.18	0.00	1.18	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	Other (specify)			0.00	0.00	0.00	18.00
	HOME HEALTH AGENCY CBSA CODES						
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			1			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).			16974			20.00
		Full Episodes					
		Without Outliers	With Outliers	LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		1.00	2.00	3.00	4.00	5.00	
	PPS ACTIVITY DATA						
21.00	Skilled Nursing Visits	6,963	1,063	218	547	8,791	21.00
22.00	Skilled Nursing Visit Charges	1,676,209	255,970	52,494	131,718	2,116,391	22.00
23.00	Physical Therapy Visits	4,828	471	34	303	5,636	23.00
24.00	Physical Therapy Visit Charges	1,092,187	106,352	7,451	68,417	1,274,407	24.00
25.00	Occupational Therapy Visits	1,375	219	3	89	1,686	25.00
26.00	Occupational Therapy Visit Charges	310,475	49,450	677	20,096	380,698	26.00
27.00	Speech Pathology Visits	208	9	0	13	230	27.00
28.00	Speech Pathology Visit Charges	49,847	2,157	0	3,115	55,119	28.00
29.00	Medical Social Service Visits	60	15	4	5	84	29.00
30.00	Medical Social Service Visit Charges	19,785	4,946	1,319	1,649	27,699	30.00
31.00	Home Health Aide Visits	692	266	5	67	1,030	31.00
32.00	Home Health Aide Visit Charges	101,897	39,169	736	9,866	151,668	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	14,126	2,043	264	1,024	17,457	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)	3,250,400	458,044	62,677	234,861	4,005,982	35.00
36.00	Total Number of Episodes (standard/non outlier)	777		82	48	907	36.00
37.00	Total Number of Outlier Episodes		54		22	76	37.00
38.00	Total Non-Routine Medical Supply Charges	22,740	8,872	410	2,109	34,131	38.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA | Provider CCN: 14-0213 | Period: From 10/01/2016 To 09/30/2017 | Worksheet S-10 | Date/Time Prepared: 2/26/2018 3:14 pm

		1.00	
	Uncompensated and indigent care cost computation		
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)	0.256038	1.00
	Medicaid (see instructions for each line)		
2.00	Net revenue from Medicaid	31,901,000	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 and/or supplemental payments from Medicaid?	Y	4.00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicaid	0	5.00
6.00	Medicaid charges	125,115,000	6.00
7.00	Medicaid cost (line 1 times line 6)	32,034,194	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)	133,194	8.00
	Children's Health Insurance Program (CHIP) (see instructions for each line)		
9.00	Net revenue from stand-alone CHIP	0	9.00
10.00	Stand-alone CHIP charges	0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)	0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then enter zero)	0	12.00
	Other state or local government indigent care program (see instructions for each line)		
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)	0	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)	0	14.00
15.00	State or local indigent care program cost (line 1 times line 14)	0	15.00
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)	0	16.00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state/local indigent care programs (see instructions for each line)		
17.00	Private grants, donations, or endowment income restricted to funding charity care	0	17.00
18.00	Government grants, appropriations or transfers for support of hospital operations	0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent care programs (sum of lines 8, 12 and 16)	133,194	19.00

		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
	Uncompensated Care (see instructions for each line)				
20.00	Charity care charges and uninsured discounts for the entire facility (see instructions)	12,553,878	3,465,783	16,019,661	20.00
21.00	Cost of patients approved for charity care and uninsured discounts (see instructions)	3,214,270	3,465,783	6,680,053	21.00
22.00	Payments received from patients for amounts previously written off as charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	3,214,270	3,465,783	6,680,053	23.00

		1.00	
24.00	Does the amount on line 20 column 2, include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?	N	24.00
25.00	If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see instructions)	11,948,000	26.00
27.00	Medicare reimbursable bad debts for the entire hospital complex (see instructions)	1,075,351	27.00
27.01	Medicare allowable bad debts for the entire hospital complex (see instructions)	1,654,385	27.01
28.00	Non-Medicare bad debt expense (line 26 minus line 27.01)	10,293,615	28.00
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)	3,214,591	29.00
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	9,894,644	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)	10,027,838	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0213 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A | Date/Time Prepared: 2/26/2018 3:14 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT		54,045,699	54,045,699	-22,857,232	31,188,467	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	0	15,982,184	15,982,184	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	901,562	35,044,827	35,946,389	0	35,946,389	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	16,855,790	48,623,829	65,479,619	3,207,261	68,686,880	5.00
7.00	00700	OPERATION OF PLANT	2,939,818	6,052,429	8,992,247	0	8,992,247	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	90,869	82,022	172,891	0	172,891	8.00
9.00	00900	HOUSEKEEPING	2,427,799	1,361,321	3,789,120	0	3,789,120	9.00
10.00	01000	DIETARY	2,244,312	2,736,583	4,980,895	-3,867,508	1,113,387	10.00
11.00	01100	CAFETERIA	0	0	0	3,867,508	3,867,508	11.00
13.00	01300	NURSING ADMINISTRATION	2,968,744	68,745	3,037,489	-93	3,037,396	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,628,152	2,422,828	4,050,980	-3,003,814	1,047,166	14.00
15.00	01500	PHARMACY	3,322,518	14,249,240	17,571,758	-12,013,184	5,558,574	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	2,564,042	1,920,549	4,484,591	0	4,484,591	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	358,455	358,455	17.00
23.00	02300	PARAMED ED PRGM	304,649	370,829	675,478	-1,345	674,133	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	23,490,166	3,378,105	26,868,271	4,609,710	31,477,981	30.00
31.00	03100	INTENSIVE CARE UNIT	6,260,807	1,637,437	7,898,244	-58,288	7,839,956	31.00
40.00	04000	SUBPROVIDER - IPF	1,919,814	373,604	2,293,418	128,639	2,422,057	40.00
41.00	04100	SUBPROVIDER - IRF	3,738,320	617,737	4,356,057	66,891	4,422,948	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	8,893,315	868,586	9,761,901	-7,281,103	2,480,798	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	9,864,294	35,362,781	45,227,075	-23,458,772	21,768,303	50.00
51.00	05100	RECOVERY ROOM	1,395,156	57,645	1,452,801	-1,454	1,451,347	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	896,152	896,152	3,463,086	4,359,238	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	8,273,076	12,192,993	20,466,069	-7,636,886	12,829,183	54.00
54.01	05401	ULTRASOUND	1,190,188	252,551	1,442,739	-5,630	1,437,109	54.01
57.00	05700	CT SCAN	1,204,794	1,101,033	2,305,827	-35,390	2,270,437	57.00
58.00	05800	MRI	682,638	645,091	1,327,729	0	1,327,729	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	3,962,738	6,305,686	10,268,424	30,292	10,298,716	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	276,500	1,725,414	2,001,914	0	2,001,914	63.00
65.00	06500	RESPIRATORY THERAPY	1,795,554	474,359	2,269,913	84,050	2,353,963	65.00
65.01	06501	SLEEP LAB	261,142	184,586	445,728	110,000	555,728	65.01
66.00	06600	PHYSICAL THERAPY	1,422,298	380,094	1,802,392	-2,156	1,800,236	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,908,120	424,338	2,332,458	-3,531	2,328,927	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,327,922	170,632	1,498,554	159,981	1,658,535	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	251,087	27,419	278,506	851,291	1,129,797	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	14,845,851	14,845,851	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	20,108,480	20,108,480	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	11,970,934	11,970,934	73.00
74.00	07400	RENAL DIALYSIS	401,020	133,376	534,396	11,816	546,212	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	499,973	224,449	724,422	79,702	804,124	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	7,592,740	2,015,037	9,607,777	381,031	9,988,808	91.00
91.01	09101	OP MENTAL HEALTH	470,844	11,413	482,257	0	482,257	91.01
91.02	09102	DIABETES CENTER	363,950	5,791	369,741	-98,559	271,182	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	1,893,421	1,173,339	3,066,760	7,783	3,074,543	101.00
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	125,588,132	237,618,549	363,206,681	0	363,206,681	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	15,136	0	15,136	0	15,136	190.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0213 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A | Date/Time Prepared: 2/26/2018 3:14 pm

		Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
			1.00	2.00	3.00	4.00	5.00	
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		TOTAL (SUM OF LINES 118 through 199)	125,603,268	237,618,549	363,221,817	0	363,221,817	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES | Provider CCN: 14-0213 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A | Date/Time Prepared: 2/26/2018 3:14 pm

		Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		
			6.00	7.00		
		GENERAL SERVICE COST CENTERS				
1.00	00100	CAP REL COSTS-BLDG & FIXT	-19,438,921	11,749,546		1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	15,982,184		2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-70,260	35,876,129		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-21,923,531	46,763,349		5.00
7.00	00700	OPERATION OF PLANT	-3,120	8,989,127		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	172,891		8.00
9.00	00900	HOUSEKEEPING	0	3,789,120		9.00
10.00	01000	DIETARY	0	1,113,387		10.00
11.00	01100	CAFETERIA	-2,433,266	1,434,242		11.00
13.00	01300	NURSING ADMINISTRATION	-117	3,037,279		13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-15,649	1,031,517		14.00
15.00	01500	PHARMACY	-2,276	5,556,298		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-2,444	4,482,147		16.00
17.00	01700	SOCIAL SERVICE	0	358,455		17.00
23.00	02300	PARAMED ED PRGM	-295,793	378,340		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	-1,305,633	30,172,348		30.00
31.00	03100	INTENSIVE CARE UNIT	-251,694	7,588,262		31.00
40.00	04000	SUBPROVIDER - IPF	-123,326	2,298,731		40.00
41.00	04100	SUBPROVIDER - IRF	-105,736	4,317,212		41.00
42.00	04200	SUBPROVIDER	0	0		42.00
43.00	04300	NURSERY	-5,227	2,475,571		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	-2,203	21,766,100		50.00
51.00	05100	RECOVERY ROOM	0	1,451,347		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	4,359,238		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,146,904	15,976,087		54.00
54.01	05401	ULTRASOUND	0	1,437,109		54.01
57.00	05700	CT SCAN	0	2,270,437		57.00
58.00	05800	MRI	0	1,327,729		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	-26,154	10,272,562		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	2,001,914		63.00
65.00	06500	RESPIRATORY THERAPY	-77,087	2,276,876		65.00
65.01	06501	SLEEP LAB	-110,000	445,728		65.01
66.00	06600	PHYSICAL THERAPY	0	1,800,236		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,328,927		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	-165,421	1,493,114		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	-856,622	273,175		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	14,845,851		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	20,108,480		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	11,970,934		73.00
74.00	07400	RENAL DIALYSIS	-6,466	539,746		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	-90,000	714,124		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	-873,097	9,115,711		91.00
91.01	09101	OP MENTAL HEALTH	-270	481,987		91.01
91.02	09102	DIABETES CENTER	-2,444	268,738		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	3,074,543		101.00
		SPECIAL PURPOSE COST CENTERS				
109.00	10900	PANCREAS ACQUISITION	0	0		109.00
110.00	11000	INTESTINAL ACQUISITION	0	0		110.00
111.00	11100	ISLET ACQUISITION	0	0		111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	-45,039,853	318,166,828		118.00
		NONREIMBURSABLE COST CENTERS				
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	15,136		190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0		192.00
200.00		TOTAL (SUM OF LINES 118 through 199)	-45,039,853	318,181,964		200.00

RECLASSIFICATIONS | Provider CCN: 14-0213 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-6 | Date/Time Prepared: 2/26/2018 3:14 pm

		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - STERILE PROCESSING					
1.00	ADULTS & PEDIATRICS	30.00	13,268	25,876		1.00
2.00	OPERATING ROOM	50.00	849,178	1,656,044		2.00
3.00	DELIVERY ROOM & LABOR ROOM	52.00	59,708	116,441		3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	6,634	12,938		4.00
5.00	CLINIC	90.00	3,791	7,393		5.00
6.00	EMERGENCY	91.00	15,164	29,572		6.00
	0		947,743	1,848,264		
	C - CAPITAL INSURANCE					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	171,743		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	268,301		2.00
	0		0	440,044		
	D - CHARGEABLE DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	11,970,934		1.00
	0		0	11,970,934		
	E - MALPRACTICE INSURANCE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	6,606,747		1.00
	0		0	6,606,747		
	F - DEPRECIATION					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	15,810,441		1.00
	0		0	15,810,441		
	G - PHYSICIAN FEES					
1.00	ADULTS & PEDIATRICS	30.00	0	1,345,871		1.00
2.00	INTENSIVE CARE UNIT	31.00	0	276,587		2.00
3.00	SUBPROVIDER - IPF	40.00	0	128,660		3.00
4.00	SUBPROVIDER - IRF	41.00	0	105,736		4.00
5.00	OPERATING ROOM	50.00	0	15,834		5.00
6.00	RADIOLOGY-DIAGNOSTIC	54.00	0	7,333		6.00
7.00	LABORATORY	60.00	0	34,000		7.00
8.00	RESPIRATORY THERAPY	65.00	0	88,332		8.00
9.00	SLEEP LAB	65.01	0	110,000		9.00
10.00	ELECTROCARDIOLOGY	69.00	0	160,000		10.00
11.00	ELECTROENCEPHALOGRAPHY	70.00	0	862,500		11.00
12.00	RENAL DIALYSIS	74.00	0	12,600		12.00
13.00	CLINIC	90.00	0	90,000		13.00
14.00	EMERGENCY	91.00	0	429,950		14.00
15.00	DIABETES CENTER	91.02	0	5,000		15.00
16.00	HOME HEALTH AGENCY	101.00	0	35,000		16.00
	0		0	3,707,403		
	H - LABOR AND DELIVERY					
1.00	DELIVERY ROOM & LABOR ROOM	52.00	3,663,986	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	3,601,991	0		2.00
	0		7,265,977	0		
	I - SOCIAL SERVICES					
1.00	SOCIAL SERVICE	17.00	358,455	0		1.00
	0		358,455	0		
	K - CHARGEABLE SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	14,845,851		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	398,071		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
	TOTALS		0	15,243,922		

RECLASSIFICATIONS | Provider CCN: 14-0213 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-6 | Date/Time Prepared: 2/26/2018 3:14 pm

	Increases					
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	L - DIABETES MANAGEMENT					
1.00	ADULTS & PEDIATRICS	30.00	101,937	1,622		1.00
	0		101,937	1,622		
	M - DIETARY RECLASS					
1.00	CAFETERIA	11.00	1,742,638	2,124,870		1.00
	0		1,742,638	2,124,870		
	N - IMPLANTABLE DEVICES					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	20,108,480		1.00
2.00		0.00	0	0		2.00
	TOTALS		0	20,108,480		
500.00	Grand Total: Increases		10,416,750	77,862,727		500.00

RECLASSIFICATIONS | Provider CCN: 14-0213 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-6 | Date/Time Prepared: 2/26/2018 3:14 pm

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	A - STERILE PROCESSING						
1.00	CENTRAL SERVICES & SUPPLY	14.00	947,743	1,848,264	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
	0		947,743	1,848,264			
	C - CAPITAL INSURANCE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	440,044	9		1.00
2.00		0.00	0	0	0		2.00
	0		0	440,044			
	D - CHARGEABLE DRUGS						
1.00	PHARMACY	15.00	0	11,970,934	0		1.00
	0		0	11,970,934			
	E - MALPRACTICE INSURANCE						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	6,606,747	9		1.00
	0		0	6,606,747			
	F - DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	15,810,441	9		1.00
	0		0	15,810,441			
	G - PHYSICIAN FEES						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	3,707,403	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
16.00		0.00	0	0	0		16.00
	0		0	3,707,403			
	H - LABOR AND DELIVERY						
1.00	NURSERY	43.00	7,265,977	0	0		1.00
2.00		0.00	0	0	0		2.00
	0		7,265,977	0			
	I - SOCIAL SERVICES						
1.00	ADMINISTRATIVE & GENERAL	5.00	358,455	0	0		1.00
	0		358,455	0			
	K - CHARGEABLE SUPPLIES						
1.00	NURSING ADMINISTRATION	13.00	0	93	0		1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	207,807	0		2.00
3.00	PHARMACY	15.00	0	42,250	0		3.00
4.00	PARAMED ED PRGM	23.00	0	1,345	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	480,855	0		5.00
6.00	INTENSIVE CARE UNIT	31.00	0	334,875	0		6.00
7.00	SUBPROVIDER - IPF	40.00	0	21	0		7.00
8.00	SUBPROVIDER - IRF	41.00	0	38,845	0		8.00
9.00	NURSERY	43.00	0	15,126	0		9.00
10.00	OPERATING ROOM	50.00	0	9,506,218	0		10.00
11.00	RECOVERY ROOM	51.00	0	1,454	0		11.00
12.00	DELIVERY ROOM & LABOR ROOM	52.00	0	377,049	0		12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	4,028,921	0		13.00
14.00	ULTRASOUND	54.01	0	5,630	0		14.00
15.00	CT SCAN	57.00	0	35,390	0		15.00
16.00	LABORATORY	60.00	0	3,708	0		16.00
17.00	RESPIRATORY THERAPY	65.00	0	4,282	0		17.00
18.00	PHYSICAL THERAPY	66.00	0	2,156	0		18.00
19.00	OCCUPATIONAL THERAPY	67.00	0	3,531	0		19.00
20.00	ELECTROCARDIOLOGY	69.00	0	19	0		20.00
21.00	ELECTROENCEPHALOGRAPHY	70.00	0	11,209	0		21.00
22.00	RENAL DIALYSIS	74.00	0	784	0		22.00
23.00	CLINIC	90.00	0	21,482	0		23.00
24.00	EMERGENCY	91.00	0	93,655	0		24.00
25.00	HOME HEALTH AGENCY	101.00	0	27,217	0		25.00
	TOTALS		0	15,243,922			

RECLASSIFICATIONS | Provider CCN: 14-0213 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-6 | Date/Time Prepared: 2/26/2018 3:14 pm

	Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
	L - DIABETES MANAGEMENT						
1.00	DIABETES CENTER	91.02	101,937	1,622	0		1.00
	0		101,937	1,622			
	M - DIETARY RECLASS						
1.00	DIETARY	10.00	1,742,638	2,124,870	0		1.00
	0		1,742,638	2,124,870			
	N - IMPLANTABLE DEVICES						
1.00	OPERATING ROOM	50.00	0	16,473,610	0		1.00
2.00	RADIOLOGY-DIAGNOSTIC	54.00	0	3,634,870	0		2.00
	TOTALS		0	20,108,480			
500.00	Grand Total: Decreases		10,416,750	77,862,727			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0213 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-7 Part I | Date/Time Prepared: 2/26/2018 3:14 pm

		Beginning Balances	Acquisitions: Purchases	Acquisitions: Donation	Acquisitions: Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	19,840,244	0	0	0	0	1.00
2.00	Land Improvements	13,585,486	418,402	0	418,402	0	2.00
3.00	Buildings and Fixtures	333,260,750	0	0	0	0	3.00
4.00	Building Improvements	3,544,772	1,272,647	0	1,272,647	0	4.00
5.00	Fixed Equipment	16,844,850	1,729,735	0	1,729,735	0	5.00
6.00	Movable Equipment	213,411,088	21,273,413	0	21,273,413	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	600,487,190	24,694,197	0	24,694,197	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	600,487,190	24,694,197	0	24,694,197	0	10.00

		Ending Balance	Fully Depreciated Assets	
		6.00	7.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES			
1.00	Land	19,840,244	0	1.00
2.00	Land Improvements	14,003,888	0	2.00
3.00	Buildings and Fixtures	333,260,750	0	3.00
4.00	Building Improvements	4,817,419	0	4.00
5.00	Fixed Equipment	18,574,585	0	5.00
6.00	Movable Equipment	234,684,501	0	6.00
7.00	HIT designated Assets	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	625,181,387	0	8.00
9.00	Reconciling Items	0	0	9.00
10.00	Total (line 8 minus line 9)	625,181,387	0	10.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0213 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-7 Part II | Date/Time Prepared: 2/26/2018 3:14 pm

	Cost Center Description	SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2						
1.00	CAP REL COSTS-BLDG & FIXT	27,534,080	175,000	19,067,201	7,198,060	71,358	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	27,534,080	175,000	19,067,201	7,198,060	71,358	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	54,045,699		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		2.00
3.00	Total (sum of lines 1-2)	0	54,045,699		3.00

RECONCILIATION OF CAPITAL COSTS CENTERS | Provider CCN: 14-0213 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-7 Part III Date/Time Prepared: 2/26/2018 3:14 pm

	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	390,496,885	0	390,496,885	0.624614	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	234,684,501	0	234,684,501	0.375386	0	2.00
3.00	Total (sum of lines 1-2)	625,181,386	0	625,181,386	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	3,948,548	175,000	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	15,982,184	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	19,930,732	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	356,580	7,198,060	71,358	0	11,749,546	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	15,982,184	2.00
3.00	Total (sum of lines 1-2)	356,580	7,198,060	71,358	0	27,731,730	3.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0213 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-8 | Date/Time Prepared: 2/26/2018 3:14 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)		0		0.00	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9.00	Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-7,485,178			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	1,285,410			0	12.00
13.00	Laundry and linen service		0		0.00	0	13.00
14.00	Cafeteria-employees and guests		0		0.00	0	14.00
15.00	Rental of quarters to employee and others		0		0.00	0	15.00
16.00	Sale of medical and surgical supplies to other than patients		0		0.00	0	16.00
17.00	Sale of drugs to other than patients		0		0.00	0	17.00
18.00	Sale of medical records and abstracts		0		0.00	0	18.00
19.00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19.00
20.00	Vending machines		0		0.00	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)		0		0.00	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0		0.00	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3	0	RESPIRATORY THERAPY	65.00		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		0	*** Cost Center Deleted ***	114.00		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29.00	Physicians' assistant		0		0.00	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	67.00		30.00
30.99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00

ADJUSTMENTS TO EXPENSES | Provider CCN: 14-0213 | Period: From 10/01/2016 To 09/30/2017 | Worksheet A-8 | Date/Time Prepared: 2/26/2018 3:14 pm

	Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted: Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
33.00	OTHER ADJUSTMENTS (SPECIFY) (3)		0		0.00	0	33.00
33.01	1996 DSR INTEXP	A	14,351	CAP REL COSTS-BLDG & FIXT	1.00	9	33.01
33.02	OTHER REVENUE-CENTRAL SUPPLY	B	-15,649	CENTRAL SERVICES & SUPPLY	14.00	0	33.02
33.03	TELEPHONE BENEFITS	B	-16,858	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33.03
38.00	PHYSICIANS	A	-178,858	ADMINISTRATIVE & GENERAL	5.00	0	38.00
39.00	CONTRIBUTIONS EXPENSE	B	-99,692	ADMINISTRATIVE & GENERAL	5.00	9	39.00
40.00	BAD DEBTS	A	1,138,370	ADMINISTRATIVE & GENERAL	5.00	0	40.00
41.00	AHA & IHA DUES-POLITICAL LOBBY	B	-42,914	ADMINISTRATIVE & GENERAL	5.00	0	41.00
42.00	OTHER REV A & G	B	-3,523,154	ADMINISTRATIVE & GENERAL	5.00	0	42.00
43.00	TELEPHONE COSTS	A	-63,987	ADMINISTRATIVE & GENERAL	5.00	0	43.00
44.00	COMMUNITY RELATIONS	A	-1,272,088	ADMINISTRATIVE & GENERAL	5.00	0	44.00
44.01	OTHER REV-EMPLOYEE BENEFIS	B	-53,402	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	44.01
44.02	OTHER REV-OPERATION & PLANT	B	-3,120	OPERATION OF PLANT	7.00	0	44.02
44.03	OTHER REV-CAF'-EMP & GUESTS	B	-2,428,731	CAFETERIA	11.00	0	44.03
44.04	OTHER REV-VENDING MACHINES	B	-4,535	CAFETERIA	11.00	0	44.04
44.05	OTHER REV-PARAMED ED PROGRAM	B	-295,793	PARAMED ED PRGM	23.00	0	44.05
44.06	OTHER REV-A & P	B	-327	ADULTS & PEDIATRICS	30.00	0	44.06
44.07	OTHER REV-PSYCH	B	-270	OP MENTAL HEALTH	91.01	0	44.07
44.08	OTHER REV-RADILOGY	B	-4,550	RADIOLOGY-DIAGNOSTIC	54.00	0	44.08
44.09	OTHER REV-LAB	B	-332	LABORATORY	60.00	0	44.09
44.11	OTHER REV-CARDIAC CATH	B	-38,390	ELECTROCARDIOLOGY	69.00	0	44.11
44.12	OTHER REV-ER	B	-483,017	EMERGENCY	91.00	0	44.12
44.14	INVESTMENT INCOME	B	-18,710,621	CAP REL COSTS-BLDG & FIXT	1.00	11	44.14
44.15	OTHER REV-MED REC	B	-2,444	MEDICAL RECORDS & LIBRARY	16.00	0	44.15
44.19	ADMINISTRATIVE MISC	B	-176,748	ADMINISTRATIVE & GENERAL	5.00	0	44.19
44.21	PROVIDER TAX ASSESSMENT IN A&G	B	-11,826,728	ADMINISTRATIVE & GENERAL	5.00	0	44.21
44.22	OTHER REV - CAPITAL EXPENSE	B	-742,651	CAP REL COSTS-BLDG & FIXT	1.00	9	44.22
44.23	OTHER REV - NURSING ADMIN	B	-117	NURSING ADMINISTRATION	13.00	0	44.23
44.24	OTHER REV - PHARMACY	B	-2,276	PHARMACY	15.00	0	44.24
44.25	OTHER REV - NURSERY	B	-5,227	NURSERY	43.00	0	44.25
44.26	OTHER REV - ADULTS & PEDS	B	-327	ADULTS & PEDIATRICS	30.00	0	44.26
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-45,039,853				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 10/01/2016 To 09/30/2017 | Worksheet A-8-1 | Date/Time Prepared: 2/26/2018 3:14 pm

	Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	MANAGEMENT FEE	6,609,979	8,483,356	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	JV OPERATING EXP	3,158,787	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.			9,768,766	8,483,356	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 10/01/2016 To 09/30/2017	Worksheet A-8-1 Date/Time Prepared: 2/26/2018 3:14 pm

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:			
1.00	-1,873,377	0		1.00
2.00	3,158,787	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	1,285,410			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 10/01/2016 To 09/30/2017 | Worksheet A-8-2 | Date/Time Prepared: 2/26/2018 3:14 pm

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	4,004,355	4,004,355	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	1,345,871	1,297,961	47,910	177,200	480	2.00
3.00	31.00	INTENSIVE CARE UNIT	276,587	226,587	50,000	154,100	336	3.00
4.00	40.00	SUBPROVIDER - IPF	128,660	119,660	9,000	154,100	72	4.00
5.00	41.00	SUBPROVIDER - IRF	105,736	105,736	0	208,000	0	5.00
6.00	50.00	OPERATING ROOM	15,834	1,667	14,167	177,200	160	6.00
7.00	65.00	RESPIRATORY THERAPY	88,332	70,000	18,332	177,200	132	7.00
8.00	69.00	ELECTROCARDIOLOGY	160,000	100,000	60,000	177,200	387	8.00
9.00	70.00	ELECTROENCEPHALOGRAPHY	862,500	838,500	24,000	177,200	69	9.00
10.00	74.00	RENAL DIALYSIS	12,600	0	12,600	177,200	72	10.00
11.00	90.00	CLINIC	90,000	90,000	0	177,200	0	11.00
12.00	91.00	EMERGENCY	429,950	364,950	65,000	177,200	468	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	96	14.00
15.00	91.02	DIABETES CENTER	5,000	0	5,000	177,200	30	15.00
16.00	54.00	RADIOLOGY-DIAGNOSTIC	7,333	7,333	0	177,200	0	16.00
200.00			7,676,758	7,361,749	315,009		2,302	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	40,892	2,045	0	0	0	2.00
3.00	31.00	INTENSIVE CARE UNIT	24,893	1,245	0	0	0	3.00
4.00	40.00	SUBPROVIDER - IPF	5,334	267	0	0	0	4.00
5.00	41.00	SUBPROVIDER - IRF	0	0	0	0	0	5.00
6.00	50.00	OPERATING ROOM	13,631	682	0	0	0	6.00
7.00	65.00	RESPIRATORY THERAPY	11,245	562	0	0	0	7.00
8.00	69.00	ELECTROCARDIOLOGY	32,969	1,648	0	0	0	8.00
9.00	70.00	ELECTROENCEPHALOGRAPHY	5,878	294	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	39,870	1,994	0	0	0	12.00
13.00	65.01	SLEEP LAB	0	0	0	0	0	13.00
14.00	60.00	LABORATORY	8,178	409	0	0	0	14.00
15.00	91.02	DIABETES CENTER	2,556	128	0	0	0	15.00
16.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	16.00
200.00			191,580	9,581	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	4,004,355		1.00
2.00	30.00	ADULTS & PEDIATRICS	0	40,892	7,018	1,304,979		2.00
3.00	31.00	INTENSIVE CARE UNIT	0	24,893	25,107	251,694		3.00
4.00	40.00	SUBPROVIDER - IPF	0	5,334	3,666	123,326		4.00
5.00	41.00	SUBPROVIDER - IRF	0	0	0	105,736		5.00
6.00	50.00	OPERATING ROOM	0	13,631	536	2,203		6.00
7.00	65.00	RESPIRATORY THERAPY	0	11,245	7,087	77,087		7.00
8.00	69.00	ELECTROCARDIOLOGY	0	32,969	27,031	127,031		8.00
9.00	70.00	ELECTROENCEPHALOGRAPHY	0	5,878	18,122	856,622		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	90,000		11.00
12.00	91.00	EMERGENCY	0	39,870	25,130	390,080		12.00
13.00	65.01	SLEEP LAB	0	0	0	110,000		13.00
14.00	60.00	LABORATORY	0	8,178	822	25,822		14.00
15.00	91.02	DIABETES CENTER	0	2,556	2,444	2,444		15.00
16.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	7,333		16.00
200.00			0	191,580	123,429	7,485,178		200.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0213 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part I Date/Time Prepared: 2/26/2018 3:14 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	11,749,546	11,749,546				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	15,982,184		15,982,184			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	35,876,129	43,538	4,762	35,924,429		4.00
5.00	00500	ADMINISTRATIVE & GENERAL	46,763,349	2,700,600	7,421,822	4,752,602	61,638,373	5.00
7.00	00700	OPERATION OF PLANT	8,989,127	144,565	58,812	846,912	10,039,416	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	172,891	49,726	0	26,178	248,795	8.00
9.00	00900	HOUSEKEEPING	3,789,120	123,281	48,487	699,408	4,660,296	9.00
10.00	01000	DIETARY	1,113,387	489,954	12,314	144,524	1,760,179	10.00
11.00	01100	CAFETERIA	1,434,242	0	41,655	502,024	1,977,921	11.00
13.00	01300	NURSING ADMINISTRATION	3,037,279	62,018	57,357	855,245	4,011,899	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,031,517	395,353	228,706	196,014	1,851,590	14.00
15.00	01500	PHARMACY	5,556,298	163,196	0	957,161	6,676,655	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,482,147	23,095	8,410	738,657	5,252,309	16.00
17.00	01700	SOCIAL SERVICE	358,455	0	0	103,265	461,720	17.00
23.00	02300	PARAMED ED PRGM	378,340	18,071	46,884	87,764	531,059	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	30,172,348	2,541,074	532,075	7,837,965	41,083,462	30.00
31.00	03100	INTENSIVE CARE UNIT	7,588,262	366,113	241,686	1,803,632	9,999,693	31.00
40.00	04000	SUBPROVIDER - IPF	2,298,731	238,907	22,128	553,066	3,112,832	40.00
41.00	04100	SUBPROVIDER - IRF	4,317,212	434,902	25,288	1,076,946	5,854,348	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	2,475,571	981,699	170,136	468,808	4,096,214	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	21,766,100	1,183,861	2,083,666	3,086,369	28,119,996	50.00
51.00	05100	RECOVERY ROOM	1,451,347	93,523	36,049	401,921	1,982,840	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	4,359,238	0	310,983	1,072,733	5,742,954	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,976,087	528,619	2,316,145	2,385,244	21,206,095	54.00
54.01	05401	ULTRASOUND	1,437,109	64,735	190,662	342,873	2,035,379	54.01
57.00	05700	CT SCAN	2,270,437	58,072	449,508	347,081	3,125,098	57.00
58.00	05800	MRI	1,327,729	74,870	293,803	196,656	1,893,058	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	10,272,562	12,917	50,946	1,141,597	11,478,022	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,001,914	0	5,825	79,655	2,087,394	63.00
65.00	06500	RESPIRATORY THERAPY	2,276,876	42,373	57,636	517,269	2,894,154	65.00
65.01	06501	SLEEP LAB	445,728	0	30,207	75,231	551,166	65.01
66.00	06600	PHYSICAL THERAPY	1,800,236	5,369	27,317	409,740	2,242,662	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,328,927	0	12,820	549,697	2,891,444	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,493,114	31,397	83,644	382,552	1,990,707	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	273,175	22,427	9,473	72,334	377,409	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	14,845,851	0	0	0	14,845,851	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	20,108,480	0	0	0	20,108,480	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	11,970,934	0	615,797	0	12,586,731	73.00
74.00	07400	RENAL DIALYSIS	539,746	62,449	34,618	115,527	752,340	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	714,124	0	2,921	145,126	862,171	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	9,115,711	687,696	445,852	2,191,708	12,440,967	91.00
91.01	09101	OP MENTAL HEALTH	481,987	66,137	1,902	135,642	685,668	91.01
91.02	09102	DIABETES CENTER	268,738	0	495	75,481	344,714	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	3,074,543	0	1,393	545,462	3,621,398	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 10/01/2016 To 09/30/2017 | Worksheet B Part I Date/Time Prepared: 2/26/2018 3:14 pm

		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
			0	1.00	2.00	4.00	4A	
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	318,166,828	11,710,537	15,982,184	35,920,069	318,123,459	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	15,136	39,009	0	4,360	58,505	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments					0	200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	318,181,964	11,749,546	15,982,184	35,924,429	318,181,964	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0213 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part I | Date/Time Prepared: 2/26/2018 3:14 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	61,638,373					5.00
7.00	00700	OPERATION OF PLANT	2,412,120	12,451,536				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	59,777	69,877	378,449			8.00
9.00	00900	HOUSEKEEPING	1,119,706	173,239	0	5,953,241		9.00
10.00	01000	DIETARY	422,909	688,500	0	335,736	3,207,324	10.00
11.00	01100	CAFETERIA	475,225	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	963,919	87,150	0	42,497	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	444,872	555,563	910	270,911	0	14.00
15.00	01500	PHARMACY	1,604,167	229,328	0	111,828	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,261,946	32,454	0	15,826	0	16.00
17.00	01700	SOCIAL SERVICE	110,935	0	0	0	0	17.00
23.00	02300	PARAMED ED PRGM	127,595	25,393	15,236	12,383	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	9,870,844	3,570,797	130,111	1,741,241	1,902,973	30.00
31.00	03100	INTENSIVE CARE UNIT	2,402,576	514,473	24,612	250,875	630,184	31.00
40.00	04000	SUBPROVIDER - IPF	747,905	335,720	470	163,708	200,407	40.00
41.00	04100	SUBPROVIDER - IRF	1,406,595	611,138	4,871	298,012	473,760	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	984,177	1,379,514	0	672,698	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	6,756,251	1,663,599	49,795	811,227	0	50.00
51.00	05100	RECOVERY ROOM	476,407	131,421	1,283	64,085	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,379,831	0	14,346	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,095,082	742,832	21,742	362,230	0	54.00
54.01	05401	ULTRASOUND	489,030	90,968	2,130	44,359	0	54.01
57.00	05700	CT SCAN	750,852	81,604	2,130	39,793	0	57.00
58.00	05800	MRI	454,836	105,210	3,063	51,304	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	2,757,767	18,151	0	8,851	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	501,528	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	695,364	59,544	0	29,036	0	65.00
65.01	06501	SLEEP LAB	132,426	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	538,833	7,545	0	3,679	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	694,713	0	9,716	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	478,297	44,120	124	21,515	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	90,678	31,514	0	15,368	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,566,938	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,831,364	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,024,151	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	180,761	87,756	0	42,793	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	207,150	0	60	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	2,989,129	966,372	97,850	471,236	0	91.00
91.01	09101	OP MENTAL HEALTH	164,742	92,937	0	45,319	0	91.01
91.02	09102	DIABETES CENTER	82,823	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	870,095	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	61,624,316	12,396,719	378,449	5,926,510	3,207,324	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	14,057	54,817	0	26,731	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 10/01/2016 To 09/30/2017 | Worksheet B Part I Date/Time Prepared: 2/26/2018 3:14 pm

	Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	61,638,373	12,451,536	378,449	5,953,241	3,207,324	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0213 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part I | Date/Time Prepared: 2/26/2018 3:14 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	2,453,146					11.00
13.00	01300	NURSING ADMINISTRATION	72,883	5,178,348				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	71,106	0	3,194,952			14.00
15.00	01500	PHARMACY	60,440	0	35,842	8,718,260		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	79,994	0	1,545	0	6,644,074	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
23.00	02300	PARAMED ED PRGM	8,888	0	15,838	38,996	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	611,508	2,885,330	236,798	4,645	2,629,388	30.00
31.00	03100	INTENSIVE CARE UNIT	135,101	635,041	77,302	15,599	809,358	31.00
40.00	04000	SUBPROVIDER - IPF	51,552	0	3,914	0	211,218	40.00
41.00	04100	SUBPROVIDER - IRF	92,437	436,486	15,636	0	205,413	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	202,651	954,237	24,912	1,657	283,958	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	236,426	0	352,460	3,516	0	50.00
51.00	05100	RECOVERY ROOM	26,665	0	4,744	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	44,855	3,200	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	211,539	0	107,059	16,322	0	54.00
54.01	05401	ULTRASOUND	24,887	0	13,471	0	0	54.01
57.00	05700	CT SCAN	28,442	0	33,190	0	0	57.00
58.00	05800	MRI	12,443	0	15,978	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	120,880	0	421,850	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	7,111	0	21,674	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	47,996	0	25,393	0	0	65.00
65.01	06501	SLEEP LAB	7,111	0	3,001	0	0	65.01
66.00	06600	PHYSICAL THERAPY	30,220	0	1,060	0	611,628	66.00
67.00	06700	OCCUPATIONAL THERAPY	44,441	0	5,231	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	31,998	0	4,304	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	7,111	0	666	0	142,064	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	1,606,182	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	8,634,325	0	73.00
74.00	07400	RENAL DIALYSIS	7,111	32,674	9,541	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	8,888	0	5,110	0	26,808	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	190,208	0	98,245	0	1,724,239	91.00
91.01	09101	OP MENTAL HEALTH	12,443	0	989	0	0	91.01
91.02	09102	DIABETES CENTER	8,888	40,214	506	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	194,366	7,656	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2,451,368	5,178,348	3,194,952	8,718,260	6,644,074	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,778	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 10/01/2016 To 09/30/2017 | Worksheet B Part I Date/Time Prepared: 2/26/2018 3:14 pm

	Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	2,453,146	5,178,348	3,194,952	8,718,260	6,644,074	202.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0213 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part I | Date/Time Prepared: 2/26/2018 3:14 pm

		Cost Center Description	SOCIAL SERVICE	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	23.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	572,655					17.00
23.00	02300	PARAMED ED PRGM	0	775,388				23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	497,412	0	65,164,509	0	65,164,509	30.00
31.00	03100	INTENSIVE CARE UNIT	30,504	29,294	15,554,612	0	15,554,612	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	4,827,726	0	4,827,726	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	9,398,696	0	9,398,696	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	8,600,018	0	8,600,018	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	37,993,270	0	37,993,270	50.00
51.00	05100	RECOVERY ROOM	0	0	2,687,445	0	2,687,445	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	33,689	7,218,875	0	7,218,875	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	27,762,901	0	27,762,901	54.00
54.01	05401	ULTRASOUND	0	0	2,700,224	0	2,700,224	54.01
57.00	05700	CT SCAN	0	0	4,061,109	0	4,061,109	57.00
58.00	05800	MRI	0	0	2,535,892	0	2,535,892	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	14,805,521	0	14,805,521	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	2,617,707	0	2,617,707	63.00
65.00	06500	RESPIRATORY THERAPY	0	7,324	3,758,811	0	3,758,811	65.00
65.01	06501	SLEEP LAB	0	0	693,704	0	693,704	65.01
66.00	06600	PHYSICAL THERAPY	0	0	3,435,627	0	3,435,627	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	3,645,545	0	3,645,545	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	29,294	2,600,359	0	2,600,359	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	664,810	0	664,810	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	20,018,971	0	20,018,971	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	24,939,844	0	24,939,844	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	24,245,207	0	24,245,207	73.00
74.00	07400	RENAL DIALYSIS	0	0	1,112,976	0	1,112,976	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	7,118	0	1,117,305	0	1,117,305	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	37,621	675,787	19,691,654	0	19,691,654	91.00
91.01	09101	OP MENTAL HEALTH	0	0	1,002,098	0	1,002,098	91.01
91.02	09102	DIABETES CENTER	0	0	477,145	0	477,145	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	4,693,515	0	4,693,515	101.00
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	572,655	775,388	318,026,076	0	318,026,076	118.00

COST ALLOCATION - GENERAL SERVICE COSTS | Provider CCN: 14-0213 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part I Date/Time Prepared: 2/26/2018 3:14 pm

		Cost Center Description	SOCIAL SERVICE	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	23.00	24.00	25.00	26.00	
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	155,888	0	155,888	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments		0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	572,655	775,388	318,181,964	0	318,181,964	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0213 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part II | Date/Time Prepared: 2/26/2018 3:14 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	43,538	4,762	48,300	48,300	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	0	2,700,600	7,421,822	10,122,422	6,384	5.00
7.00	00700	OPERATION OF PLANT	0	144,565	58,812	203,377	1,138	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	49,726	0	49,726	35	8.00
9.00	00900	HOUSEKEEPING	0	123,281	48,487	171,768	940	9.00
10.00	01000	DIETARY	0	489,954	12,314	502,268	194	10.00
11.00	01100	CAFETERIA	0	0	41,655	41,655	674	11.00
13.00	01300	NURSING ADMINISTRATION	0	62,018	57,357	119,375	1,149	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	395,353	228,706	624,059	263	14.00
15.00	01500	PHARMACY	0	163,196	0	163,196	1,286	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	23,095	8,410	31,505	992	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	139	17.00
23.00	02300	PARAMED ED PRGM	0	18,071	46,884	64,955	118	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	2,541,074	532,075	3,073,149	10,571	30.00
31.00	03100	INTENSIVE CARE UNIT	0	366,113	241,686	607,799	2,423	31.00
40.00	04000	SUBPROVIDER - IPF	0	238,907	22,128	261,035	743	40.00
41.00	04100	SUBPROVIDER - IRF	0	434,902	25,288	460,190	1,447	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	981,699	170,136	1,151,835	630	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	1,183,861	2,083,666	3,267,527	4,146	50.00
51.00	05100	RECOVERY ROOM	0	93,523	36,049	129,572	540	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	310,983	310,983	1,441	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	528,619	2,316,145	2,844,764	3,204	54.00
54.01	05401	ULTRASOUND	0	64,735	190,662	255,397	461	54.01
57.00	05700	CT SCAN	0	58,072	449,508	507,580	466	57.00
58.00	05800	MRI	0	74,870	293,803	368,673	264	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	12,917	50,946	63,863	1,534	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	5,825	5,825	107	63.00
65.00	06500	RESPIRATORY THERAPY	0	42,373	57,636	100,009	695	65.00
65.01	06501	SLEEP LAB	0	0	30,207	30,207	101	65.01
66.00	06600	PHYSICAL THERAPY	0	5,369	27,317	32,686	550	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	12,820	12,820	738	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	31,397	83,644	115,041	514	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	22,427	9,473	31,900	97	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	615,797	615,797	0	73.00
74.00	07400	RENAL DIALYSIS	0	62,449	34,618	97,067	155	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	2,921	2,921	195	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	687,696	445,852	1,133,548	2,944	91.00
91.01	09101	OP MENTAL HEALTH	0	66,137	1,902	68,039	182	91.01
91.02	09102	DIABETES CENTER	0	0	495	495	101	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	1,393	1,393	733	101.00
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	0	11,710,537	15,982,184	27,692,721	48,294	118.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0213 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part II Date/Time Prepared: 2/26/2018 3:14 pm

		Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS BLDG & FIXT	CAPITAL RELATED COSTS MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
			0	1.00	2.00	2A	4.00	
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	39,009	0	39,009	6	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments				0		200.00
201.00		Negative Cost Centers		0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	0	11,749,546	15,982,184	27,731,730	48,300	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0213 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part II | Date/Time Prepared: 2/26/2018 3:14 pm

		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
			5.00	7.00	8.00	9.00	10.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL	10,128,806					5.00
7.00	00700	OPERATION OF PLANT	396,376	600,891				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	9,823	3,372	62,956			8.00
9.00	00900	HOUSEKEEPING	183,998	8,360	0	365,066		9.00
10.00	01000	DIETARY	69,495	33,226	0	20,588	625,771	10.00
11.00	01100	CAFETERIA	78,092	0	0	0	0	11.00
13.00	01300	NURSING ADMINISTRATION	158,398	4,206	0	2,606	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	73,104	26,811	151	16,613	0	14.00
15.00	01500	PHARMACY	263,608	11,067	0	6,858	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	207,372	1,566	0	970	0	16.00
17.00	01700	SOCIAL SERVICE	18,230	0	0	0	0	17.00
23.00	02300	PARAMED ED PRGM	20,967	1,225	2,535	759	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	1,622,010	172,320	21,646	106,778	371,283	30.00
31.00	03100	INTENSIVE CARE UNIT	394,808	24,828	4,094	15,384	122,953	31.00
40.00	04000	SUBPROVIDER - IPF	122,901	16,201	78	10,039	39,101	40.00
41.00	04100	SUBPROVIDER - IRF	231,141	29,493	810	18,275	92,434	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	161,727	66,573	0	41,251	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	1,110,234	80,283	8,284	49,746	0	50.00
51.00	05100	RECOVERY ROOM	78,286	6,342	213	3,930	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	226,743	0	2,386	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	837,259	35,848	3,617	22,213	0	54.00
54.01	05401	ULTRASOUND	80,361	4,390	354	2,720	0	54.01
57.00	05700	CT SCAN	123,385	3,938	354	2,440	0	57.00
58.00	05800	MRI	74,742	5,077	509	3,146	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	453,175	876	0	543	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	82,414	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	114,267	2,874	0	1,781	0	65.00
65.01	06501	SLEEP LAB	21,761	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	88,545	364	0	226	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	114,160	0	1,616	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	78,597	2,129	21	1,319	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	14,901	1,521	0	942	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	586,144	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	793,923	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	496,949	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	29,704	4,235	0	2,624	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	34,040	0	10	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	491,194	46,636	16,278	28,897	0	91.00
91.01	09101	OP MENTAL HEALTH	27,072	4,485	0	2,779	0	91.01
91.02	09102	DIABETES CENTER	13,610	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	142,980	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	10,126,496	598,246	62,956	363,427	625,771	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,310	2,645	0	1,639	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 10/01/2016 To 09/30/2017 | Worksheet B Part II Date/Time Prepared: 2/26/2018 3:14 pm

	Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	10,128,806	600,891	62,956	365,066	625,771	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0213 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part II | Date/Time Prepared: 2/26/2018 3:14 pm

		Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	120,421					11.00
13.00	01300	NURSING ADMINISTRATION	3,578	289,312				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	3,490	0	744,491			14.00
15.00	01500	PHARMACY	2,967	0	8,352	457,334		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,927	0	360	0	246,692	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
23.00	02300	PARAMED ED PRGM	436	0	3,691	2,046	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	30,017	161,203	55,179	244	97,629	30.00
31.00	03100	INTENSIVE CARE UNIT	6,632	35,479	18,013	818	30,051	31.00
40.00	04000	SUBPROVIDER - IPF	2,531	0	912	0	7,842	40.00
41.00	04100	SUBPROVIDER - IRF	4,538	24,386	3,643	0	7,627	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	9,948	53,313	5,805	87	10,543	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	11,606	0	82,131	184	0	50.00
51.00	05100	RECOVERY ROOM	1,309	0	1,105	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	10,452	168	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	10,384	0	24,947	856	0	54.00
54.01	05401	ULTRASOUND	1,222	0	3,139	0	0	54.01
57.00	05700	CT SCAN	1,396	0	7,734	0	0	57.00
58.00	05800	MRI	611	0	3,723	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	5,934	0	98,301	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	349	0	5,051	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	2,356	0	5,917	0	0	65.00
65.01	06501	SLEEP LAB	349	0	699	0	0	65.01
66.00	06600	PHYSICAL THERAPY	1,483	0	247	0	22,710	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,182	0	1,219	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,571	0	1,003	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	349	0	155	0	5,275	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	374,274	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	452,931	0	73.00
74.00	07400	RENAL DIALYSIS	349	1,825	2,223	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	436	0	1,191	0	995	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	9,337	0	22,893	0	64,020	91.00
91.01	09101	OP MENTAL HEALTH	611	0	230	0	0	91.01
91.02	09102	DIABETES CENTER	436	2,247	118	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	10,859	1,784	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	120,334	289,312	744,491	457,334	246,692	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	87	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 10/01/2016 To 09/30/2017 | Worksheet B Part II Date/Time Prepared: 2/26/2018 3:14 pm

	Cost Center Description	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118 through 201)	120,421	289,312	744,491	457,334	246,692	202.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0213 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part II | Date/Time Prepared: 2/26/2018 3:14 pm

		Cost Center Description	SOCIAL SERVICE	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	23.00	24.00	25.00	26.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	18,369					17.00
23.00	02300	PARAMED ED PRGM	0	96,732				23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	15,956		5,737,985	0	5,737,985	30.00
31.00	03100	INTENSIVE CARE UNIT	978		1,264,260	0	1,264,260	31.00
40.00	04000	SUBPROVIDER - IPF	0		461,383	0	461,383	40.00
41.00	04100	SUBPROVIDER - IRF	0		873,984	0	873,984	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	42.00
43.00	04300	NURSERY	0		1,501,712	0	1,501,712	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		4,614,141	0	4,614,141	50.00
51.00	05100	RECOVERY ROOM	0		221,297	0	221,297	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0		552,173	0	552,173	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0		3,783,092	0	3,783,092	54.00
54.01	05401	ULTRASOUND	0		348,044	0	348,044	54.01
57.00	05700	CT SCAN	0		647,293	0	647,293	57.00
58.00	05800	MRI	0		456,745	0	456,745	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	0		624,226	0	624,226	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0		93,746	0	93,746	63.00
65.00	06500	RESPIRATORY THERAPY	0		227,899	0	227,899	65.00
65.01	06501	SLEEP LAB	0		53,117	0	53,117	65.01
66.00	06600	PHYSICAL THERAPY	0		146,811	0	146,811	66.00
67.00	06700	OCCUPATIONAL THERAPY	0		132,735	0	132,735	67.00
68.00	06800	SPEECH PATHOLOGY	0		0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0		200,195	0	200,195	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0		55,140	0	55,140	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0		960,418	0	960,418	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0		793,923	0	793,923	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0		1,565,677	0	1,565,677	73.00
74.00	07400	RENAL DIALYSIS	0		138,182	0	138,182	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	228		40,016	0	40,016	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	1,207		1,816,954	0	1,816,954	91.00
91.01	09101	OP MENTAL HEALTH	0		103,398	0	103,398	91.01
91.02	09102	DIABETES CENTER	0		17,007	0	17,007	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		157,749	0	157,749	101.00
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0		0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0		0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0		0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	18,369	0	27,589,302	0	27,589,302	118.00

ALLOCATION OF CAPITAL RELATED COSTS | Provider CCN: 14-0213 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B Part II Date/Time Prepared: 2/26/2018 3:14 pm

		Cost Center Description	SOCIAL SERVICE	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	23.00	24.00	25.00	26.00	
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		45,696	0	45,696	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		0	0	0	192.00
200.00		Cross Foot Adjustments		96,732	96,732	0	96,732	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118 through 201)	18,369	96,732	27,731,730	0	27,731,730	202.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0213 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B-1 | Date/Time Prepared: 2/26/2018 3:14 pm

		Cost Center Description	CAPITAL RELATED COSTS BLDG & FIXT (SQUARE FEET)	CAPITAL RELATED COSTS MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT	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	124,701,706			4.00
5.00	00500	ADMINISTRATIVE & GENERAL	125,237	6,355,683	16,497,335	-61,638,373	256,543,591	5.00
7.00	00700	OPERATION OF PLANT	6,704	50,364	2,939,818	0	10,039,416	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,306	0	90,869	0	248,795	8.00
9.00	00900	HOUSEKEEPING	5,717	41,522	2,427,799	0	4,660,296	9.00
10.00	01000	DIETARY	22,721	10,545	501,674	0	1,760,179	10.00
11.00	01100	CAFETERIA	0	35,671	1,742,638	0	1,977,921	11.00
13.00	01300	NURSING ADMINISTRATION	2,876	49,118	2,968,744	0	4,011,899	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	18,334	195,853	680,409	0	1,851,590	14.00
15.00	01500	PHARMACY	7,568	0	3,322,518	0	6,676,655	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,071	7,202	2,564,042	0	5,252,309	16.00
17.00	01700	SOCIAL SERVICE	0	0	358,455	0	461,720	17.00
23.00	02300	PARAMED ED PRGM	838	40,149	304,649	0	531,059	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	117,839	455,643	27,207,362	0	41,083,462	30.00
31.00	03100	INTENSIVE CARE UNIT	16,978	206,968	6,260,807	0	9,999,693	31.00
40.00	04000	SUBPROVIDER - IPF	11,079	18,949	1,919,814	0	3,112,832	40.00
41.00	04100	SUBPROVIDER - IRF	20,168	21,655	3,738,320	0	5,854,348	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	45,525	145,696	1,627,338	0	4,096,214	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	10,713,472	0	28,119,996	50.00
51.00	05100	RECOVERY ROOM	4,337	30,871	1,395,156	0	1,982,840	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	266,311	3,723,694	0	5,742,954	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	24,514	1,983,434	8,279,710	0	21,206,095	54.00
54.01	05401	ULTRASOUND	3,002	163,274	1,190,188	0	2,035,379	54.01
57.00	05700	CT SCAN	2,693	384,937	1,204,794	0	3,125,098	57.00
58.00	05800	MRI	3,472	251,599	682,638	0	1,893,058	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	599	43,628	3,962,738	0	11,478,022	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	4,988	276,500	0	2,087,394	63.00
65.00	06500	RESPIRATORY THERAPY	1,965	49,357	1,795,554	0	2,894,154	65.00
65.01	06501	SLEEP LAB	0	25,868	261,142	0	551,166	65.01
66.00	06600	PHYSICAL THERAPY	249	23,393	1,422,298	0	2,242,662	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	10,978	1,908,120	0	2,891,444	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,456	71,629	1,327,922	0	1,990,707	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,040	8,112	251,087	0	377,409	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	14,845,851	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	20,108,480	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	527,339	0	0	12,586,731	73.00
74.00	07400	RENAL DIALYSIS	2,896	29,645	401,020	0	752,340	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	503,764	0	862,171	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	7,607,904	0	12,440,967	91.00
91.01	09101	OP MENTAL HEALTH	3,067	1,629	470,844	0	685,668	91.01
91.02	09102	DIABETES CENTER	0	424	262,013	0	344,714	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	1,893,421	0	3,621,398	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 10/01/2016 To 09/30/2017 | Worksheet B-1 | Date/Time Prepared: 2/26/2018 3:14 pm

		Cost Center Description	CAPITAL RELATED COSTS					
			BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
			1.00	2.00	4.00	5A	5.00	
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	543,061	13,686,362	124,686,570	-61,638,373	256,485,086	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,809	0	15,136	0	58,505	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)	11,749,546	15,982,184	35,924,429		61,638,373	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	21.563944	1.167745	0.288083		0.240265	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			48,300		10,128,806	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.000387		0.039482	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0213 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B-1 | Date/Time Prepared: 2/26/2018 3:14 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (NUMBER HOUSED)	
			7.00	8.00	9.00	10.00	11.00	
		GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT	410,910					7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,306	2,672,275				8.00
9.00	00900	HOUSEKEEPING	5,717	0	402,887			9.00
10.00	01000	DIETARY	22,721	0	22,721	267,988		10.00
11.00	01100	CAFETERIA	0	0	0	0	1,380	11.00
13.00	01300	NURSING ADMINISTRATION	2,876	0	2,876	0	41	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	18,334	6,426	18,334	0	40	14.00
15.00	01500	PHARMACY	7,568	0	7,568	0	34	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,071	0	1,071	0	45	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
23.00	02300	PARAMED ED PRGM	838	107,581	838	0	5	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	117,839	918,732	117,839	159,003	344	30.00
31.00	03100	INTENSIVE CARE UNIT	16,978	173,789	16,978	52,655	76	31.00
40.00	04000	SUBPROVIDER - IPF	11,079	3,322	11,079	16,745	29	40.00
41.00	04100	SUBPROVIDER - IRF	20,168	34,395	20,168	39,585	52	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	45,525	0	45,525	0	114	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	351,610	54,900	0	133	50.00
51.00	05100	RECOVERY ROOM	4,337	9,056	4,337	0	15	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	101,296	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	24,514	153,522	24,514	0	119	54.00
54.01	05401	ULTRASOUND	3,002	15,043	3,002	0	14	54.01
57.00	05700	CT SCAN	2,693	15,043	2,693	0	16	57.00
58.00	05800	MRI	3,472	21,625	3,472	0	7	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	599	0	599	0	68	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	4	63.00
65.00	06500	RESPIRATORY THERAPY	1,965	0	1,965	0	27	65.00
65.01	06501	SLEEP LAB	0	0	0	0	4	65.01
66.00	06600	PHYSICAL THERAPY	249	0	249	0	17	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	68,604	0	0	25	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	1,456	879	1,456	0	18	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	1,040	0	1,040	0	4	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	2,896	0	2,896	0	4	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	421	0	0	5	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	690,931	31,891	0	107	91.00
91.01	09101	OP MENTAL HEALTH	3,067	0	3,067	0	7	91.01
91.02	09102	DIABETES CENTER	0	0	0	0	5	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	409,101	2,672,275	401,078	267,988	1,379	118.00
		NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,809	0	1,809	0	1	190.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0213 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B-1 | Date/Time Prepared: 2/26/2018 3:14 pm

		Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (NUMBER HOUSED)	
			7.00	8.00	9.00	10.00	11.00	
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	12,451,536	378,449	5,953,241	3,207,324	2,453,146	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	30.302344	0.141621	14.776453	11.968163	1,777.642029	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	600,891	62,956	365,066	625,771	120,421	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	1.462342	0.023559	0.906125	2.335071	87.261594	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0213 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B-1 | Date/Time Prepared: 2/26/2018 3:14 pm

		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	1,285,648					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	29,530,707				14.00
15.00	01500	PHARMACY	0	331,282	12,087,304			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	14,277	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	146,387	54,066	0	0	23.00
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	716,352	2,188,707	6,440	15,399	2,446	30.00
31.00	03100	INTENSIVE CARE UNIT	157,664	714,499	21,627	4,740	150	31.00
40.00	04000	SUBPROVIDER - IPF	0	36,178	0	1,237	0	40.00
41.00	04100	SUBPROVIDER - IRF	108,368	144,518	0	1,203	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	236,912	230,261	2,297	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	3,257,761	4,875	0	0	50.00
51.00	05100	RECOVERY ROOM	0	43,848	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	414,594	4,436	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	989,535	22,629	0	0	54.00
54.01	05401	ULTRASOUND	0	124,515	0	0	0	54.01
57.00	05700	CT SCAN	0	306,769	0	0	0	57.00
58.00	05800	MRI	0	147,679	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	3,899,124	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	200,331	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	234,707	0	0	0	65.00
65.01	06501	SLEEP LAB	0	27,739	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	9,796	0	3,582	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	48,348	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	39,780	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	6,155	0	832	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	14,845,851	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	11,970,934	0	0	73.00
74.00	07400	RENAL DIALYSIS	8,112	88,190	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	47,228	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	908,067	0	10,098	185	91.00
91.01	09101	OP MENTAL HEALTH	0	9,139	0	0	0	91.01
91.02	09102	DIABETES CENTER	9,984	4,676	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	48,256	70,766	0	0	0	101.00
		SPECIAL PURPOSE COST CENTERS						
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	1,285,648	29,530,707	12,087,304	38,911	2,816	118.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0213 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B-1 | Date/Time Prepared: 2/26/2018 3:14 pm

		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)	5,178,348	3,194,952	8,718,260	6,644,074	572,655	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	4.027812	0.108191	0.721274	170.750533	203.357599	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	289,312	744,491	457,334	246,692	18,369	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.225032	0.025211	0.037836	6.339904	6.523082	205.00

COST ALLOCATION - STATISTICAL BASIS | Provider CCN: 14-0213 | Period: From 10/01/2016 To 09/30/2017 | Worksheet B-1 | Date/Time Prepared: 2/26/2018 3:14 pm

		Cost Center Description	PARAMED ED PRGM (ASSIGNED TIME)		
			23.00		
		GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP			2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT			4.00
5.00	00500	ADMINISTRATIVE & GENERAL			5.00
7.00	00700	OPERATION OF PLANT			7.00
8.00	00800	LAUNDRY & LINEN SERVICE			8.00
9.00	00900	HOUSEKEEPING			9.00
10.00	01000	DIETARY			10.00
11.00	01100	CAFETERIA			11.00
13.00	01300	NURSING ADMINISTRATION			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY			14.00
15.00	01500	PHARMACY			15.00
16.00	01600	MEDICAL RECORDS & LIBRARY			16.00
17.00	01700	SOCIAL SERVICE			17.00
23.00	02300	PARAMED ED PRGM	8,470		23.00
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	0		30.00
31.00	03100	INTENSIVE CARE UNIT	320		31.00
40.00	04000	SUBPROVIDER - IPF	0		40.00
41.00	04100	SUBPROVIDER - IRF	0		41.00
42.00	04200	SUBPROVIDER	0		42.00
43.00	04300	NURSERY	0		43.00
44.00	04400	SKILLED NURSING FACILITY	0		44.00
45.00	04500	NURSING FACILITY	0		45.00
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0		50.00
51.00	05100	RECOVERY ROOM	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	368		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	80		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	320		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	7,382		91.00
91.01	09101	OP MENTAL HEALTH	0		91.01
91.02	09102	DIABETES CENTER	0		91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
		OTHER REIMBURSABLE COST CENTERS			
94.00	09400	HOME PROGRAM DIALYSIS	0		94.00
99.00	09900	CMHC	0		99.00
99.10	09910	CORF	0		99.10
101.00	10100	HOME HEALTH AGENCY	0		101.00
		SPECIAL PURPOSE COST CENTERS			
109.00	10900	PANCREAS ACQUISITION	0		109.00
110.00	11000	INTESTINAL ACQUISITION	0		110.00
111.00	11100	ISLET ACQUISITION	0		111.00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	8,470		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 10/01/2016 To 09/30/2017 | Worksheet B-1 | Date/Time Prepared: 2/26/2018 3:14 pm

		Cost Center Description	PARAMED ED PRGM (ASSIGNED TIME)		
			23.00		
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		192.00
200.00		Cross Foot Adjustments			200.00
201.00		Negative Cost Centers			201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	775,388		202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	91.545218		203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	96,732		204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	11.420543		205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0213 | Period: From 10/01/2016 To 09/30/2017 | Worksheet C Part I Date/Time Prepared: 2/26/2018 3:14 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Costs Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	65,164,509		65,164,509	7,018	65,171,527	30.00
31.00	03100	INTENSIVE CARE UNIT	15,554,612		15,554,612	25,107	15,579,719	31.00
40.00	04000	SUBPROVIDER - IPF	4,827,726		4,827,726	3,666	4,831,392	40.00
41.00	04100	SUBPROVIDER - IRF	9,398,696		9,398,696	0	9,398,696	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	42.00
43.00	04300	NURSERY	8,600,018		8,600,018	0	8,600,018	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	37,993,270		37,993,270	536	37,993,806	50.00
51.00	05100	RECOVERY ROOM	2,687,445		2,687,445	0	2,687,445	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,218,875		7,218,875	0	7,218,875	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	27,762,901		27,762,901	0	27,762,901	54.00
54.01	05401	ULTRASOUND	2,700,224		2,700,224	0	2,700,224	54.01
57.00	05700	CT SCAN	4,061,109		4,061,109	0	4,061,109	57.00
58.00	05800	MRI	2,535,892		2,535,892	0	2,535,892	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	14,805,521		14,805,521	822	14,806,343	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,617,707		2,617,707	0	2,617,707	63.00
65.00	06500	RESPIRATORY THERAPY	3,758,811	0	3,758,811	7,087	3,765,898	65.00
65.01	06501	SLEEP LAB	693,704	0	693,704	0	693,704	65.01
66.00	06600	PHYSICAL THERAPY	3,435,627	0	3,435,627	0	3,435,627	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,645,545	0	3,645,545	0	3,645,545	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,600,359		2,600,359	27,031	2,627,390	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	664,810		664,810	18,122	682,932	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	20,018,971		20,018,971	0	20,018,971	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	24,939,844		24,939,844	0	24,939,844	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	24,245,207		24,245,207	0	24,245,207	73.00
74.00	07400	RENAL DIALYSIS	1,112,976		1,112,976	6,466	1,119,442	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000	CLINIC	1,117,305		1,117,305	0	1,117,305	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	19,691,654		19,691,654	25,130	19,716,784	91.00
91.01	09101	OP MENTAL HEALTH	1,002,098		1,002,098	0	1,002,098	91.01
91.02	09102	DIABETES CENTER	477,145		477,145	2,444	479,589	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	10,652,184		10,652,184		10,652,184	92.00
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0		0	0	0	94.00
99.00	09900	CMHC	0		0		0	99.00
99.10	09910	CORF	0		0		0	99.10
101.00	10100	HOME HEALTH AGENCY	4,693,515		4,693,515		4,693,515	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)	328,678,260	0	328,678,260	123,429	328,801,689	200.00
201.00		Less Observation Beds	10,652,184		10,652,184		10,652,184	201.00
202.00		Total (see instructions)	318,026,076	0	318,026,076	123,429	318,149,505	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0213 | Period: From 10/01/2016 To 09/30/2017 | Worksheet C Part I Date/Time Prepared: 2/26/2018 3:14 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	64,639,161		64,639,161			30.00
31.00	03100	INTENSIVE CARE UNIT	21,405,671		21,405,671			31.00
40.00	04000	SUBPROVIDER - IPF	6,807,290		6,807,290			40.00
41.00	04100	SUBPROVIDER - IRF	16,092,475		16,092,475			41.00
42.00	04200	SUBPROVIDER	0		0			42.00
43.00	04300	NURSERY	10,020,732		10,020,732			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	73,396,849	107,025,568	180,422,417	0.210580	0.000000	50.00
51.00	05100	RECOVERY ROOM	17,315,400	13,746,482	31,061,882	0.086519	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,775,618	772,964	9,548,582	0.756015	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	45,571,767	131,264,199	176,835,966	0.156998	0.000000	54.00
54.01	05401	ULTRASOUND	9,247,209	20,847,603	30,094,812	0.089724	0.000000	54.01
57.00	05700	CT SCAN	36,392,573	82,998,545	119,391,118	0.034015	0.000000	57.00
58.00	05800	MRI	10,261,611	24,219,997	34,481,608	0.073543	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	65,900,866	110,359,298	176,260,164	0.083998	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.	6,313,288	2,806,192	9,119,480	0.287046	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	14,901,712	2,650,189	17,551,901	0.214154	0.000000	65.00
65.01	06501	SLEEP LAB	0	3,835,685	3,835,685	0.180855	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	8,939,308	542,160	9,481,468	0.362352	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,379,367	6,615,552	10,994,919	0.331566	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	12,416,153	11,782,956	24,199,109	0.107457	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	727,715	2,165,418	2,893,133	0.229789	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	28,250,148	16,820,474	45,070,622	0.444169	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	32,255,108	14,631,053	46,886,161	0.531923	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	48,362,278	20,999,237	69,361,515	0.349548	0.000000	73.00
74.00	07400	RENAL DIALYSIS	3,605,579	201,000	3,806,579	0.292382	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	13,925	976,152	990,077	1.128503	0.000000	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0.000000	0.000000	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0.000000	0.000000	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0	0.000000	0.000000	90.03
91.00	09100	EMERGENCY	29,370,318	70,632,939	100,003,257	0.196910	0.000000	91.00
91.01	09101	OP MENTAL HEALTH	0	1,698,208	1,698,208	0.590091	0.000000	91.01
91.02	09102	DIABETES CENTER	74,117	327,542	401,659	1.187936	0.000000	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,700,955	11,372,665	13,073,620	0.814785	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0.000000	0.000000	94.00
99.00	09900	CMHC	0	0	0			99.00
99.10	09910	CORF	0	0	0			99.10
101.00	10100	HOME HEALTH AGENCY	0	5,673,989	5,673,989			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)	577,137,193	664,966,067	1,242,103,260			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	577,137,193	664,966,067	1,242,103,260			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0213 | Period: From 10/01/2016 To 09/30/2017 | Worksheet C Part I Date/Time Prepared: 2/26/2018 3:14 pm

Title XVIII | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio		
			11.00		
		INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - IPF			40.00
41.00	04100	SUBPROVIDER - IRF			41.00
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	0.210583		50.00
51.00	05100	RECOVERY ROOM	0.086519		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.756015		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.156998		54.00
54.01	05401	ULTRASOUND	0.089724		54.01
57.00	05700	CT SCAN	0.034015		57.00
58.00	05800	MRI	0.073543		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.084003		60.00
60.01	06001	BLOOD LABORATORY	0.000000		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.287046		63.00
65.00	06500	RESPIRATORY THERAPY	0.214558		65.00
65.01	06501	SLEEP LAB	0.180855		65.01
66.00	06600	PHYSICAL THERAPY	0.362352		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.331566		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.108574		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.236053		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.444169		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.531923		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.349548		73.00
74.00	07400	RENAL DIALYSIS	0.294081		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	1.128503		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	0.197161		91.00
91.01	09101	OP MENTAL HEALTH	0.590091		91.01
91.02	09102	DIABETES CENTER	1.194020		91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.814785		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 10/01/2016 To 09/30/2017 | Worksheet C Part I Date/Time Prepared: 2/26/2018 3:14 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs Total Costs	RCE Disallowance	Total Costs	
			1.00	2.00	3.00	4.00	5.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	65,164,509		65,164,509	7,018	65,171,527	30.00
31.00	03100	INTENSIVE CARE UNIT	15,554,612		15,554,612	25,107	15,579,719	31.00
40.00	04000	SUBPROVIDER - IPF	4,827,726		4,827,726	3,666	4,831,392	40.00
41.00	04100	SUBPROVIDER - IRF	9,398,696		9,398,696	0	9,398,696	41.00
42.00	04200	SUBPROVIDER	0		0	0	0	42.00
43.00	04300	NURSERY	8,600,018		8,600,018	0	8,600,018	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	37,993,270		37,993,270	536	37,993,806	50.00
51.00	05100	RECOVERY ROOM	2,687,445		2,687,445	0	2,687,445	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,218,875		7,218,875	0	7,218,875	52.00
53.00	05300	ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	27,762,901		27,762,901	0	27,762,901	54.00
54.01	05401	ULTRASOUND	2,700,224		2,700,224	0	2,700,224	54.01
57.00	05700	CT SCAN	4,061,109		4,061,109	0	4,061,109	57.00
58.00	05800	MRI	2,535,892		2,535,892	0	2,535,892	58.00
59.00	05900	CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000	LABORATORY	14,805,521		14,805,521	822	14,806,343	60.00
60.01	06001	BLOOD LABORATORY	0		0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,617,707		2,617,707	0	2,617,707	63.00
65.00	06500	RESPIRATORY THERAPY	3,758,811	0	3,758,811	7,087	3,765,898	65.00
65.01	06501	SLEEP LAB	693,704	0	693,704	0	693,704	65.01
66.00	06600	PHYSICAL THERAPY	3,435,627	0	3,435,627	0	3,435,627	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,645,545	0	3,645,545	0	3,645,545	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,600,359		2,600,359	27,031	2,627,390	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	664,810		664,810	18,122	682,932	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	20,018,971		20,018,971	0	20,018,971	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	24,939,844		24,939,844	0	24,939,844	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	24,245,207		24,245,207	0	24,245,207	73.00
74.00	07400	RENAL DIALYSIS	1,112,976		1,112,976	6,466	1,119,442	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0		0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000	CLINIC	1,117,305		1,117,305	0	1,117,305	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	19,691,654		19,691,654	25,130	19,716,784	91.00
91.01	09101	OP MENTAL HEALTH	1,002,098		1,002,098	0	1,002,098	91.01
91.02	09102	DIABETES CENTER	477,145		477,145	2,444	479,589	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	10,652,184		10,652,184		10,652,184	92.00
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0		0	0	0	94.00
99.00	09900	CMHC	0		0		0	99.00
99.10	09910	CORF	0		0		0	99.10
101.00	10100	HOME HEALTH AGENCY	4,693,515		4,693,515		4,693,515	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)	328,678,260	0	328,678,260	123,429	328,801,689	200.00
201.00		Less Observation Beds	10,652,184		10,652,184		10,652,184	201.00
202.00		Total (see instructions)	318,026,076	0	318,026,076	123,429	318,149,505	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0213 | Period: From 10/01/2016 To 09/30/2017 | Worksheet C Part I Date/Time Prepared: 2/26/2018 3:14 pm

Title XIX | Hospital | PPS

		Cost Center Description	Charges Inpatient	Charges Outpatient	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
			6.00	7.00	8.00	9.00	10.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	64,639,161		64,639,161			30.00
31.00	03100	INTENSIVE CARE UNIT	21,405,671		21,405,671			31.00
40.00	04000	SUBPROVIDER - IPF	6,807,290		6,807,290			40.00
41.00	04100	SUBPROVIDER - IRF	16,092,475		16,092,475			41.00
42.00	04200	SUBPROVIDER	0		0			42.00
43.00	04300	NURSERY	10,020,732		10,020,732			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	73,396,849	107,025,568	180,422,417	0.210580	0.000000	50.00
51.00	05100	RECOVERY ROOM	17,315,400	13,746,482	31,061,882	0.086519	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,775,618	772,964	9,548,582	0.756015	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	45,571,767	131,264,199	176,835,966	0.156998	0.000000	54.00
54.01	05401	ULTRASOUND	9,247,209	20,847,603	30,094,812	0.089724	0.000000	54.01
57.00	05700	CT SCAN	36,392,573	82,998,545	119,391,118	0.034015	0.000000	57.00
58.00	05800	MRI	10,261,611	24,219,997	34,481,608	0.073543	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	65,900,866	110,359,298	176,260,164	0.083998	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.	6,313,288	2,806,192	9,119,480	0.287046	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	14,901,712	2,650,189	17,551,901	0.214154	0.000000	65.00
65.01	06501	SLEEP LAB	0	3,835,685	3,835,685	0.180855	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	8,939,308	542,160	9,481,468	0.362352	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,379,367	6,615,552	10,994,919	0.331566	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	12,416,153	11,782,956	24,199,109	0.107457	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	727,715	2,165,418	2,893,133	0.229789	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	28,250,148	16,820,474	45,070,622	0.444169	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	32,255,108	14,631,053	46,886,161	0.531923	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	48,362,278	20,999,237	69,361,515	0.349548	0.000000	73.00
74.00	07400	RENAL DIALYSIS	3,605,579	201,000	3,806,579	0.292382	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	13,925	976,152	990,077	1.128503	0.000000	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0.000000	0.000000	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0.000000	0.000000	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0	0.000000	0.000000	90.03
91.00	09100	EMERGENCY	29,370,318	70,632,939	100,003,257	0.196910	0.000000	91.00
91.01	09101	OP MENTAL HEALTH	0	1,698,208	1,698,208	0.590091	0.000000	91.01
91.02	09102	DIABETES CENTER	74,117	327,542	401,659	1.187936	0.000000	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,700,955	11,372,665	13,073,620	0.814785	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0.000000	0.000000	94.00
99.00	09900	CMHC	0	0	0			99.00
99.10	09910	CORF	0	0	0			99.10
101.00	10100	HOME HEALTH AGENCY	0	5,673,989	5,673,989			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)	577,137,193	664,966,067	1,242,103,260			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	577,137,193	664,966,067	1,242,103,260			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES | Provider CCN: 14-0213 | Period: From 10/01/2016 To 09/30/2017 | Worksheet C Part I Date/Time Prepared: 2/26/2018 3:14 pm

Title XIX | Hospital | PPS

		Cost Center Description	PPS Inpatient Ratio
			11.00
		INPATIENT ROUTINE SERVICE COST CENTERS	
30.00	03000	ADULTS & PEDIATRICS	
31.00	03100	INTENSIVE CARE UNIT	
40.00	04000	SUBPROVIDER - IPF	
41.00	04100	SUBPROVIDER - IRF	
42.00	04200	SUBPROVIDER	
43.00	04300	NURSERY	
44.00	04400	SKILLED NURSING FACILITY	
45.00	04500	NURSING FACILITY	
		ANCILLARY SERVICE COST CENTERS	
50.00	05000	OPERATING ROOM	0.210583
51.00	05100	RECOVERY ROOM	0.086519
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.756015
53.00	05300	ANESTHESIOLOGY	0.000000
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.156998
54.01	05401	ULTRASOUND	0.089724
57.00	05700	CT SCAN	0.034015
58.00	05800	MRI	0.073543
59.00	05900	CARDIAC CATHETERIZATION	0.000000
60.00	06000	LABORATORY	0.084003
60.01	06001	BLOOD LABORATORY	0.000000
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.287046
65.00	06500	RESPIRATORY THERAPY	0.214558
65.01	06501	SLEEP LAB	0.180855
66.00	06600	PHYSICAL THERAPY	0.362352
67.00	06700	OCCUPATIONAL THERAPY	0.331566
68.00	06800	SPEECH PATHOLOGY	0.000000
69.00	06900	ELECTROCARDIOLOGY	0.108574
70.00	07000	ELECTROENCEPHALOGRAPHY	0.236053
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.444169
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.531923
73.00	07300	DRUGS CHARGED TO PATIENTS	0.349548
74.00	07400	RENAL DIALYSIS	0.294081
		OUTPATIENT SERVICE COST CENTERS	
88.00	08800	RURAL HEALTH CLINIC	0.000000
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000
90.00	09000	CLINIC	1.128503
90.01	09001	HOMER GLEN LAB	0.000000
90.02	09002	HOMER GLEN FEC	0.000000
90.03	09003	WOMEN'S HEALTH	0.000000
91.00	09100	EMERGENCY	0.197161
91.01	09101	OP MENTAL HEALTH	0.590091
91.02	09102	DIABETES CENTER	1.194020
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.814785
		OTHER REIMBURSABLE COST CENTERS	
94.00	09400	HOME PROGRAM DIALYSIS	0.000000
99.00	09900	CMHC	
99.10	09910	CORF	
101.00	10100	HOME HEALTH AGENCY	
		SPECIAL PURPOSE COST CENTERS	
109.00	10900	PANCREAS ACQUISITION	
110.00	11000	INTESTINAL ACQUISITION	
111.00	11100	ISLET ACQUISITION	
200.00		Subtotal (see instructions)	
201.00		Less Observation Beds	
202.00		Total (see instructions)	

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

Provider CCN: 14-0213 | Period: From 10/01/2016 To 09/30/2017 | Worksheet C Part II | Date/Time Prepared: 2/26/2018 3:14 pm

Title XIX | Hospital | PPS

		Cost Center Description	Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	37,993,270	4,614,141	33,379,129	0	0	50.00
51.00	05100	RECOVERY ROOM	2,687,445	221,297	2,466,148	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,218,875	552,173	6,666,702	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	27,762,901	3,783,092	23,979,809	0	0	54.00
54.01	05401	ULTRASOUND	2,700,224	348,044	2,352,180	0	0	54.01
57.00	05700	CT SCAN	4,061,109	647,293	3,413,816	0	0	57.00
58.00	05800	MRI	2,535,892	456,745	2,079,147	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	14,805,521	624,226	14,181,295	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,617,707	93,746	2,523,961	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	3,758,811	227,899	3,530,912	0	0	65.00
65.01	06501	SLEEP LAB	693,704	53,117	640,587	0	0	65.01
66.00	06600	PHYSICAL THERAPY	3,435,627	146,811	3,288,816	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,645,545	132,735	3,512,810	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,600,359	200,195	2,400,164	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	664,810	55,140	609,670	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	20,018,971	960,418	19,058,553	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	24,939,844	793,923	24,145,921	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	24,245,207	1,565,677	22,679,530	0	0	73.00
74.00	07400	RENAL DIALYSIS	1,112,976	138,182	974,794	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	1,117,305	40,016	1,077,289	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	19,691,654	1,816,954	17,874,700	0	0	91.00
91.01	09101	OP MENTAL HEALTH	1,002,098	103,398	898,700	0	0	91.01
91.02	09102	DIABETES CENTER	477,145	17,007	460,138	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	10,652,184	937,861	9,714,323	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	4,693,515	157,749	4,535,766	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)	225,132,699	18,687,839	206,444,860	0	0	200.00
201.00		Less Observation Beds	10,652,184	937,861	9,714,323	0	0	201.00
202.00		Total (line 200 minus line 201)	214,480,515	17,749,978	196,730,537	0	0	202.00

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

Provider CCN: 14-0213 | Period: From 10/01/2016 To 09/30/2017 | Worksheet C Part II Date/Time Prepared: 2/26/2018 3:14 pm

Title XIX | Hospital | PPS

		Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
			6.00	7.00	8.00		
		ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	37,993,270	180,422,417	0.210580		50.00
51.00	05100	RECOVERY ROOM	2,687,445	31,061,882	0.086519		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,218,875	9,548,582	0.756015		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	27,762,901	176,835,966	0.156998		54.00
54.01	05401	ULTRASOUND	2,700,224	30,094,812	0.089724		54.01
57.00	05700	CT SCAN	4,061,109	119,391,118	0.034015		57.00
58.00	05800	MRI	2,535,892	34,481,608	0.073543		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000		59.00
60.00	06000	LABORATORY	14,805,521	176,260,164	0.083998		60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,617,707	9,119,480	0.287046		63.00
65.00	06500	RESPIRATORY THERAPY	3,758,811	17,551,901	0.214154		65.00
65.01	06501	SLEEP LAB	693,704	3,835,685	0.180855		65.01
66.00	06600	PHYSICAL THERAPY	3,435,627	9,481,468	0.362352		66.00
67.00	06700	OCCUPATIONAL THERAPY	3,645,545	10,994,919	0.331566		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	2,600,359	24,199,109	0.107457		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	664,810	2,893,133	0.229789		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	20,018,971	45,070,622	0.444169		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	24,939,844	46,886,161	0.531923		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	24,245,207	69,361,515	0.349548		73.00
74.00	07400	RENAL DIALYSIS	1,112,976	3,806,579	0.292382		74.00
		OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000		89.00
90.00	09000	CLINIC	1,117,305	990,077	1.128503		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	19,691,654	100,003,257	0.196910		91.00
91.01	09101	OP MENTAL HEALTH	1,002,098	1,698,208	0.590091		91.01
91.02	09102	DIABETES CENTER	477,145	401,659	1.187936		91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	10,652,184	13,073,620	0.814785		92.00
		OTHER REIMBURSABLE COST CENTERS					
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0.000000		94.00
99.00	09900	CMHC	0	0	0.000000		99.00
99.10	09910	CORF	0	0	0.000000		99.10
101.00	10100	HOME HEALTH AGENCY	4,693,515	5,673,989	0.827198		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)	225,132,699	1,123,137,931			200.00
201.00		Less Observation Beds	10,652,184	0			201.00
202.00		Total (line 200 minus line 201)	214,480,515	1,123,137,931			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 14-0213 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part I Date/Time Prepared: 2/26/2018 3:14 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	5,737,985	0	5,737,985	68,921	83.25	30.00
31.00	INTENSIVE CARE UNIT	1,264,260		1,264,260	8,011	157.82	31.00
40.00	SUBPROVIDER - IPF	461,383	0	461,383	6,051	76.25	40.00
41.00	SUBPROVIDER - IRF	873,984	0	873,984	7,859	111.21	41.00
42.00	SUBPROVIDER	0	0	0	0	0.00	42.00
43.00	NURSERY	1,501,712		1,501,712	7,132	210.56	43.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
45.00	NURSING FACILITY	0		0	0	0.00	45.00
200.00	Total (lines 30 through 199)	9,839,324		9,839,324	97,974		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	26,478	2,204,294	30.00
31.00	INTENSIVE CARE UNIT	3,768	594,666	31.00
40.00	SUBPROVIDER - IPF	1,224	93,330	40.00
41.00	SUBPROVIDER - IRF	5,243	583,074	41.00
42.00	SUBPROVIDER	0	0	42.00
43.00	NURSERY	0	0	43.00
44.00	SKILLED NURSING FACILITY	0	0	44.00
45.00	NURSING FACILITY	0	0	45.00
200.00	Total (lines 30 through 199)	36,713	3,475,364	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-0213 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part II Date/Time Prepared: 2/26/2018 3:14 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,614,141	180,422,417	0.025574	21,493,757	549,681	50.00
51.00	05100	RECOVERY ROOM	221,297	31,061,882	0.007124	4,152,427	29,582	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	552,173	9,548,582	0.057828	26,072	1,508	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,783,092	176,835,966	0.021393	18,543,341	396,698	54.00
54.01	05401	ULTRASOUND	348,044	30,094,812	0.011565	4,307,615	49,818	54.01
57.00	05700	CT SCAN	647,293	119,391,118	0.005422	17,144,764	92,959	57.00
58.00	05800	MRI	456,745	34,481,608	0.013246	4,760,240	63,054	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	624,226	176,260,164	0.003542	29,115,093	103,126	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	93,746	9,119,480	0.010280	2,490,830	25,606	63.00
65.00	06500	RESPIRATORY THERAPY	227,899	17,551,901	0.012984	6,754,131	87,696	65.00
65.01	06501	SLEEP LAB	53,117	3,835,685	0.013848	0	0	65.01
66.00	06600	PHYSICAL THERAPY	146,811	9,481,468	0.015484	3,419,526	52,948	66.00
67.00	06700	OCCUPATIONAL THERAPY	132,735	10,994,919	0.012072	1,848,685	22,317	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	200,195	24,199,109	0.008273	6,412,992	53,055	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	55,140	2,893,133	0.019059	385,782	7,353	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	960,418	45,070,622	0.021309	18,808,291	400,786	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	793,923	46,886,161	0.016933	13,063,464	221,204	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,565,677	69,361,515	0.022573	15,399,860	347,621	73.00
74.00	07400	RENAL DIALYSIS	138,182	3,806,579	0.036301	2,108,790	76,551	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	40,016	990,077	0.040417	137	6	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	1,816,954	100,003,257	0.018169	13,171,916	239,321	91.00
91.01	09101	OP MENTAL HEALTH	103,398	1,698,208	0.060887	0	0	91.01
91.02	09102	DIABETES CENTER	17,007	401,659	0.042342	18,447	781	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	937,861	13,073,620	0.071737	724,144	51,948	92.00
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0.000000	0	0	94.00
200.00		Total (lines 50 through 199)	18,530,090	1,117,463,942		184,150,304	2,873,619	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0213 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part III Date/Time Prepared: 2/26/2018 3:14 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	29,294	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0		44.00
45.00	04500	NURSING FACILITY	0	0	0	0		45.00
200.00		Total (lines 30 through 199)	0	0	0	29,294	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	68,921	0.00	26,478	30.00
31.00	03100	INTENSIVE CARE UNIT		29,294	8,011	3.66	3,768	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	6,051	0.00	1,224	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	7,859	0.00	5,243	41.00
42.00	04200	SUBPROVIDER	0	0	0	0.00	0	42.00
43.00	04300	NURSERY		0	7,132	0.00	0	43.00
44.00	04400	SKILLED NURSING FACILITY		0	0	0.00	0	44.00
45.00	04500	NURSING FACILITY		0	0	0.00	0	45.00
200.00		Total (lines 30 through 199)		29,294	97,974		36,713	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	13,791	31.00
40.00	04000	SUBPROVIDER - IPF	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	41.00
42.00	04200	SUBPROVIDER	0	42.00
43.00	04300	NURSERY	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	44.00
45.00	04500	NURSING FACILITY	0	45.00
200.00		Total (lines 30 through 199)	13,791	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0213 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV Date/Time Prepared: 2/26/2018 3:14 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	33,689	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	7,324	65.00
65.01	06501	SLEEP LAB	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	29,294	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	0	0	675,787	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 through 199)	0	0	0	0	746,094	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0213 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV Date/Time Prepared: 2/26/2018 3:14 pm

Title XVIII | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	180,422,417	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	31,061,882	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	33,689	33,689	9,548,582	0.003528	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	176,835,966	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	30,094,812	0.000000	54.01
57.00	05700	CT SCAN	0	0	0	119,391,118	0.000000	57.00
58.00	05800	MRI	0	0	0	34,481,608	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	176,260,164	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	9,119,480	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	7,324	7,324	17,551,901	0.000417	65.00
65.01	06501	SLEEP LAB	0	0	0	3,835,685	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	9,481,468	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	10,994,919	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	29,294	29,294	24,199,109	0.001211	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	2,893,133	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	45,070,622	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	46,886,161	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	69,361,515	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	3,806,579	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000	89.00
90.00	09000	CLINIC	0	0	0	990,077	0.000000	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	0.000000	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	0.000000	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0	0	0.000000	90.03
91.00	09100	EMERGENCY	0	675,787	675,787	100,003,257	0.006758	91.00
91.01	09101	OP MENTAL HEALTH	0	0	0	1,698,208	0.000000	91.01
91.02	09102	DIABETES CENTER	0	0	0	401,659	0.000000	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	13,073,620	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0.000000	94.00
200.00		Total (lines 50 through 199)	0	746,094	746,094	1,117,463,942		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0213 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV Date/Time Prepared: 2/26/2018 3:14 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	21,493,757	0	21,841,520	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	4,152,427	0	2,785,761	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.003528	26,072	92	2,498	9	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	18,543,341	0	42,013,395	0	54.00
54.01	05401	ULTRASOUND	0.000000	4,307,615	0	3,761,922	0	54.01
57.00	05700	CT SCAN	0.000000	17,144,764	0	22,914,656	0	57.00
58.00	05800	MRI	0.000000	4,760,240	0	6,250,788	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	29,115,093	0	12,379,424	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	2,490,830	0	847,045	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000417	6,754,131	2,816	649,677	271	65.00
65.01	06501	SLEEP LAB	0.000000	0	0	1,018,911	0	65.01
66.00	06600	PHYSICAL THERAPY	0.000000	3,419,526	0	132,959	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	1,848,685	0	46,747	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.001211	6,412,992	7,766	3,401,969	4,120	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	385,782	0	556,320	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	18,808,291	0	10,757,003	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	13,063,464	0	6,608,815	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	15,399,860	0	6,032,192	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	2,108,790	0	200,605	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	89.00
90.00	09000	CLINIC	0.000000	137	0	544,877	0	90.00
90.01	09001	HOMER GLEN LAB	0.000000	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0.000000	0	0	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0.000000	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.006758	13,171,916	89,016	11,646,634	78,708	91.00
91.01	09101	OP MENTAL HEALTH	0.000000	0	0	162,895	0	91.01
91.02	09102	DIABETES CENTER	0.000000	18,447	0	32,879	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	724,144	0	3,630,895	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0.000000	0	0	0	0	94.00
200.00		Total (lines 50 through 199)		184,150,304	99,690	158,220,387	83,108	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0213 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part V Date/Time Prepared: 2/26/2018 3:14 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges: PPS Reimbursed Services (see inst.)	Charges: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Charges: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	Costs: PPS Services (see inst.)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.210580	21,841,520	0	0	4,599,387	50.00
51.00	05100	RECOVERY ROOM	0.086519	2,785,761	0	0	241,021	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.756015	2,498	0	0	1,889	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.156998	42,013,395	0	0	6,596,019	54.00
54.01	05401	ULTRASOUND	0.089724	3,761,922	0	0	337,535	54.01
57.00	05700	CT SCAN	0.034015	22,914,656	0	0	779,442	57.00
58.00	05800	MRI	0.073543	6,250,788	0	0	459,702	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.083998	12,379,424	0	0	1,039,847	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.287046	847,045	0	0	243,141	63.00
65.00	06500	RESPIRATORY THERAPY	0.214154	649,677	0	0	139,131	65.00
65.01	06501	SLEEP LAB	0.180855	1,018,911	0	0	184,275	65.01
66.00	06600	PHYSICAL THERAPY	0.362352	132,959	0	0	48,178	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.331566	46,747	0	0	15,500	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.107457	3,401,969	0	0	365,565	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.229789	556,320	0	0	127,836	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.444169	10,757,003	0	0	4,777,927	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.531923	6,608,815	68,958	0	3,515,381	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.349548	6,032,192	0	55,521	2,108,541	73.00
74.00	07400	RENAL DIALYSIS	0.292382	200,605	0	0	58,653	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	1.128503	544,877	0	0	614,895	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	0.196910	11,646,634	0	0	2,293,339	91.00
91.01	09101	OP MENTAL HEALTH	0.590091	162,895	0	0	96,123	91.01
91.02	09102	DIABETES CENTER	1.187936	32,879	0	0	39,058	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.814785	3,630,895	0	0	2,958,399	92.00
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0.000000		0			94.00
200.00		Subtotal (see instructions)		158,220,387	68,958	55,521	31,640,784	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 - line 201)		158,220,387	68,958	55,521	31,640,784	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST | Provider CCN: 14-0213 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part V Date/Time Prepared: 2/26/2018 3:14 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Costs: Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Costs: Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	
			6.00	7.00	
		ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01	05401	ULTRASOUND	0	0	54.01
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MRI	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
65.01	06501	SLEEP LAB	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	36,680	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	19,407	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	0	91.00
91.01	09101	OP MENTAL HEALTH	0	0	91.01
91.02	09102	DIABETES CENTER	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS			
94.00	09400	HOME PROGRAM DIALYSIS	0	0	94.00
200.00		Subtotal (see instructions)	36,680	19,407	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 - line 201)	36,680	19,407	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0213 | Component CCN: 14-S213 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part II Date/Time Prepared: 2/26/2018 3:14 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,614,141	180,422,417	0.025574	3,577	91	50.00
51.00	05100	RECOVERY ROOM	221,297	31,061,882	0.007124	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	552,173	9,548,582	0.057828	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,783,092	176,835,966	0.021393	10,223	219	54.00
54.01	05401	ULTRASOUND	348,044	30,094,812	0.011565	12,617	146	54.01
57.00	05700	CT SCAN	647,293	119,391,118	0.005422	23,763	129	57.00
58.00	05800	MRI	456,745	34,481,608	0.013246	6,137	81	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	624,226	176,260,164	0.003542	260,686	923	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	93,746	9,119,480	0.010280	6,654	68	63.00
65.00	06500	RESPIRATORY THERAPY	227,899	17,551,901	0.012984	14,364	187	65.00
65.01	06501	SLEEP LAB	53,117	3,835,685	0.013848	0	0	65.01
66.00	06600	PHYSICAL THERAPY	146,811	9,481,468	0.015484	5,184	80	66.00
67.00	06700	OCCUPATIONAL THERAPY	132,735	10,994,919	0.012072	2,945	36	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	200,195	24,199,109	0.008273	10,568	87	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	55,140	2,893,133	0.019059	625	12	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	960,418	45,070,622	0.021309	2,566	55	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	793,923	46,886,161	0.016933	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,565,677	69,361,515	0.022573	21,069	476	73.00
74.00	07400	RENAL DIALYSIS	138,182	3,806,579	0.036301	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	40,016	990,077	0.040417	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	1,816,954	100,003,257	0.018169	208,812	3,794	91.00
91.01	09101	OP MENTAL HEALTH	103,398	1,698,208	0.060887	0	0	91.01
91.02	09102	DIABETES CENTER	17,007	401,659	0.042342	730	31	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	13,073,620	0.000000	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0.000000	0	0	94.00
200.00		Total (lines 50 through 199)	17,592,229	1,117,463,942		590,520	6,415	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0213 | Component CCN: 14-S213 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV Date/Time Prepared: 2/26/2018 3:14 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	33,689	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	7,324	65.00
65.01	06501	SLEEP LAB	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	29,294	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	0	0	675,787	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 through 199)	0	0	0	0	746,094	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0213 | Component CCN: 14-S213 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV Date/Time Prepared: 2/26/2018 3:14 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	180,422,417	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	31,061,882	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	33,689	33,689	9,548,582	0.003528	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	176,835,966	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	30,094,812	0.000000	54.01
57.00	05700	CT SCAN	0	0	0	119,391,118	0.000000	57.00
58.00	05800	MRI	0	0	0	34,481,608	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	176,260,164	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	9,119,480	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	7,324	7,324	17,551,901	0.000417	65.00
65.01	06501	SLEEP LAB	0	0	0	3,835,685	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	9,481,468	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	10,994,919	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	29,294	29,294	24,199,109	0.001211	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	2,893,133	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	45,070,622	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	46,886,161	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	69,361,515	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	3,806,579	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000	89.00
90.00	09000	CLINIC	0	0	0	990,077	0.000000	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	0.000000	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	0.000000	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0	0	0.000000	90.03
91.00	09100	EMERGENCY	0	675,787	675,787	100,003,257	0.006758	91.00
91.01	09101	OP MENTAL HEALTH	0	0	0	1,698,208	0.000000	91.01
91.02	09102	DIABETES CENTER	0	0	0	401,659	0.000000	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	13,073,620	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0.000000	94.00
200.00		Total (lines 50 through 199)	0	746,094	746,094	1,117,463,942		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0213 | Component CCN: 14-S213 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV | Date/Time Prepared: 2/26/2018 3:14 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	3,577	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.003528	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	10,223	0	0	0	54.00
54.01	05401	ULTRASOUND	0.000000	12,617	0	0	0	54.01
57.00	05700	CT SCAN	0.000000	23,763	0	0	0	57.00
58.00	05800	MRI	0.000000	6,137	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	260,686	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	6,654	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000417	14,364	6	0	0	65.00
65.01	06501	SLEEP LAB	0.000000	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.000000	5,184	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	2,945	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.001211	10,568	13	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	625	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	2,566	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	21,069	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	89.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	HOMER GLEN LAB	0.000000	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0.000000	0	0	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0.000000	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.006758	208,812	1,411	0	0	91.00
91.01	09101	OP MENTAL HEALTH	0.000000	0	0	0	0	91.01
91.02	09102	DIABETES CENTER	0.000000	730	0	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0.000000	0	0	0	0	94.00
200.00		Total (lines 50 through 199)		590,520	1,430	0	0	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0213 | Component CCN: 14-T213 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part II | Date/Time Prepared: 2/26/2018 3:14 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,614,141	180,422,417	0.025574	90,999	2,327	50.00
51.00	05100	RECOVERY ROOM	221,297	31,061,882	0.007124	1,393	10	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	552,173	9,548,582	0.057828	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,783,092	176,835,966	0.021393	125,259	2,680	54.00
54.01	05401	ULTRASOUND	348,044	30,094,812	0.011565	120,994	1,399	54.01
57.00	05700	CT SCAN	647,293	119,391,118	0.005422	224,965	1,220	57.00
58.00	05800	MRI	456,745	34,481,608	0.013246	59,986	795	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	624,226	176,260,164	0.003542	1,186,933	4,204	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	93,746	9,119,480	0.010280	67,468	694	63.00
65.00	06500	RESPIRATORY THERAPY	227,899	17,551,901	0.012984	306,600	3,981	65.00
65.01	06501	SLEEP LAB	53,117	3,835,685	0.013848	0	0	65.01
66.00	06600	PHYSICAL THERAPY	146,811	9,481,468	0.015484	2,697,792	41,773	66.00
67.00	06700	OCCUPATIONAL THERAPY	132,735	10,994,919	0.012072	2,512,256	30,328	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	200,195	24,199,109	0.008273	44,729	370	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	55,140	2,893,133	0.019059	10,543	201	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	960,418	45,070,622	0.021309	437,357	9,320	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	793,923	46,886,161	0.016933	2,236	38	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,565,677	69,361,515	0.022573	527,586	11,909	73.00
74.00	07400	RENAL DIALYSIS	138,182	3,806,579	0.036301	136,862	4,968	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	40,016	990,077	0.040417	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	1,816,954	100,003,257	0.018169	476	9	91.00
91.01	09101	OP MENTAL HEALTH	103,398	1,698,208	0.060887	0	0	91.01
91.02	09102	DIABETES CENTER	17,007	401,659	0.042342	1,461	62	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	13,073,620	0.000000	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0.000000	0	0	94.00
200.00		Total (lines 50 through 199)	17,592,229	1,117,463,942		8,555,895	116,288	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0213 | Component CCN: 14-T213 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV Date/Time Prepared: 2/26/2018 3:14 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	33,689	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	7,324	65.00
65.01	06501	SLEEP LAB	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	29,294	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	0	0	675,787	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 through 199)	0	0	0	0	746,094	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0213 | Component CCN: 14-T213 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV | Date/Time Prepared: 2/26/2018 3:14 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	180,422,417	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	31,061,882	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	33,689	33,689	9,548,582	0.003528	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	176,835,966	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	30,094,812	0.000000	54.01
57.00	05700	CT SCAN	0	0	0	119,391,118	0.000000	57.00
58.00	05800	MRI	0	0	0	34,481,608	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	176,260,164	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	9,119,480	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	7,324	7,324	17,551,901	0.000417	65.00
65.01	06501	SLEEP LAB	0	0	0	3,835,685	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	9,481,468	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	10,994,919	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	29,294	29,294	24,199,109	0.001211	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	2,893,133	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	45,070,622	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	46,886,161	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	69,361,515	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	3,806,579	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000	89.00
90.00	09000	CLINIC	0	0	0	990,077	0.000000	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	0.000000	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	0.000000	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0	0	0.000000	90.03
91.00	09100	EMERGENCY	0	675,787	675,787	100,003,257	0.006758	91.00
91.01	09101	OP MENTAL HEALTH	0	0	0	1,698,208	0.000000	91.01
91.02	09102	DIABETES CENTER	0	0	0	401,659	0.000000	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	13,073,620	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0.000000	94.00
200.00		Total (lines 50 through 199)	0	746,094	746,094	1,117,463,942		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0213 | Component CCN: 14-T213 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV Date/Time Prepared: 2/26/2018 3:14 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	90,999	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	1,393	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.003528	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	125,259	0	0	0	54.00
54.01	05401	ULTRASOUND	0.000000	120,994	0	0	0	54.01
57.00	05700	CT SCAN	0.000000	224,965	0	0	0	57.00
58.00	05800	MRI	0.000000	59,986	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	1,186,933	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	67,468	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000417	306,600	128	0	0	65.00
65.01	06501	SLEEP LAB	0.000000	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.000000	2,697,792	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	2,512,256	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.001211	44,729	54	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	10,543	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	437,357	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	2,236	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	527,586	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	136,862	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	89.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	HOMER GLEN LAB	0.000000	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0.000000	0	0	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0.000000	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.006758	476	3	0	0	91.00
91.01	09101	OP MENTAL HEALTH	0.000000	0	0	0	0	91.01
91.02	09102	DIABETES CENTER	0.000000	1,461	0	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0.000000	0	0	0	0	94.00
200.00		Total (lines 50 through 199)		8,555,895	185	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS | Provider CCN: 14-0213 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part I Date/Time Prepared: 2/26/2018 3:14 pm

Title XIX | Hospital | PPS

	Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	ADULTS & PEDIATRICS	5,737,985	0	5,737,985	68,921	83.25	30.00
31.00	INTENSIVE CARE UNIT	1,264,260		1,264,260	8,011	157.82	31.00
40.00	SUBPROVIDER - IPF	461,383	0	461,383	6,051	76.25	40.00
41.00	SUBPROVIDER - IRF	873,984	0	873,984	7,859	111.21	41.00
42.00	SUBPROVIDER	0	0	0	0	0.00	42.00
43.00	NURSERY	1,501,712		1,501,712	7,132	210.56	43.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
45.00	NURSING FACILITY	0		0	0	0.00	45.00
200.00	Total (lines 30 through 199)	9,839,324		9,839,324	97,974		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	4,255	354,229	30.00
31.00	INTENSIVE CARE UNIT	591	93,272	31.00
40.00	SUBPROVIDER - IPF	816	62,220	40.00
41.00	SUBPROVIDER - IRF	101	11,232	41.00
42.00	SUBPROVIDER	0	0	42.00
43.00	NURSERY	526	110,755	43.00
44.00	SKILLED NURSING FACILITY	0	0	44.00
45.00	NURSING FACILITY	0	0	45.00
200.00	Total (lines 30 through 199)	6,289	631,708	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS | Provider CCN: 14-0213 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part II Date/Time Prepared: 2/26/2018 3:14 pm

Title XIX | Hospital | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,614,141	180,422,417	0.025574	0	0	50.00
51.00	05100	RECOVERY ROOM	221,297	31,061,882	0.007124	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	552,173	9,548,582	0.057828	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,783,092	176,835,966	0.021393	0	0	54.00
54.01	05401	ULTRASOUND	348,044	30,094,812	0.011565	0	0	54.01
57.00	05700	CT SCAN	647,293	119,391,118	0.005422	0	0	57.00
58.00	05800	MRI	456,745	34,481,608	0.013246	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	624,226	176,260,164	0.003542	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	93,746	9,119,480	0.010280	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	227,899	17,551,901	0.012984	0	0	65.00
65.01	06501	SLEEP LAB	53,117	3,835,685	0.013848	0	0	65.01
66.00	06600	PHYSICAL THERAPY	146,811	9,481,468	0.015484	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	132,735	10,994,919	0.012072	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	200,195	24,199,109	0.008273	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	55,140	2,893,133	0.019059	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	960,418	45,070,622	0.021309	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	793,923	46,886,161	0.016933	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,565,677	69,361,515	0.022573	0	0	73.00
74.00	07400	RENAL DIALYSIS	138,182	3,806,579	0.036301	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	40,016	990,077	0.040417	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	1,816,954	100,003,257	0.018169	0	0	91.00
91.01	09101	OP MENTAL HEALTH	103,398	1,698,208	0.060887	0	0	91.01
91.02	09102	DIABETES CENTER	17,007	401,659	0.042342	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	937,861	13,073,620	0.071737	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0.000000	0	0	94.00
200.00		Total (lines 50 through 199)	18,530,090	1,117,463,942		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS | Provider CCN: 14-0213 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part III Date/Time Prepared: 2/26/2018 3:14 pm

Title XIX | Hospital | PPS

		Cost Center Description	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health Cost	All Other Medical Education Cost	
			1A	1.00	2A	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	29,294	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	0	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0		44.00
45.00	04500	NURSING FACILITY	0	0	0	0		45.00
200.00		Total (lines 30 through 199)	0	0	0	29,294	0	200.00

		Cost Center Description	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	
			4.00	5.00	6.00	7.00	8.00	
		INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0	68,921	0.00	4,255	30.00
31.00	03100	INTENSIVE CARE UNIT		29,294	8,011	3.66	591	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	6,051	0.00	816	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	7,859	0.00	101	41.00
42.00	04200	SUBPROVIDER	0	0	0	0.00	0	42.00
43.00	04300	NURSERY		0	7,132	0.00	526	43.00
44.00	04400	SKILLED NURSING FACILITY		0	0	0.00	0	44.00
45.00	04500	NURSING FACILITY		0	0	0.00	0	45.00
200.00		Total (lines 30 through 199)		29,294	97,974		6,289	200.00

		Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	
			9.00	
		INPATIENT ROUTINE SERVICE COST CENTERS		
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	2,163	31.00
40.00	04000	SUBPROVIDER - IPF	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	41.00
42.00	04200	SUBPROVIDER	0	42.00
43.00	04300	NURSERY	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	44.00
45.00	04500	NURSING FACILITY	0	45.00
200.00		Total (lines 30 through 199)	2,163	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0213 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV Date/Time Prepared: 2/26/2018 3:14 pm

Title XIX | Hospital | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	33,689	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	7,324	65.00
65.01	06501	SLEEP LAB	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	29,294	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	0	0	675,787	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 through 199)	0	0	0	0	746,094	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0213 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV Date/Time Prepared: 2/26/2018 3:14 pm

Title XIX | Hospital | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	180,422,417	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	31,061,882	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	33,689	33,689	9,548,582	0.003528	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	176,835,966	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	30,094,812	0.000000	54.01
57.00	05700	CT SCAN	0	0	0	119,391,118	0.000000	57.00
58.00	05800	MRI	0	0	0	34,481,608	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	176,260,164	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	9,119,480	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	7,324	7,324	17,551,901	0.000417	65.00
65.01	06501	SLEEP LAB	0	0	0	3,835,685	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	9,481,468	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	10,994,919	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	29,294	29,294	24,199,109	0.001211	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	2,893,133	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	45,070,622	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	46,886,161	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	69,361,515	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	3,806,579	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000	89.00
90.00	09000	CLINIC	0	0	0	990,077	0.000000	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	0.000000	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	0.000000	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0	0	0.000000	90.03
91.00	09100	EMERGENCY	0	675,787	675,787	100,003,257	0.006758	91.00
91.01	09101	OP MENTAL HEALTH	0	0	0	1,698,208	0.000000	91.01
91.02	09102	DIABETES CENTER	0	0	0	401,659	0.000000	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	13,073,620	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0.000000	94.00
200.00		Total (lines 50 through 199)	0	746,094	746,094	1,117,463,942		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0213 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV | Date/Time Prepared: 2/26/2018 3:14 pm

Title XIX | Hospital | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.003528	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	54.01
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000417	0	0	0	0	65.00
65.01	06501	SLEEP LAB	0.000000	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.001211	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	89.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	HOMER GLEN LAB	0.000000	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0.000000	0	0	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0.000000	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.006758	0	0	0	0	91.00
91.01	09101	OP MENTAL HEALTH	0.000000	0	0	0	0	91.01
91.02	09102	DIABETES CENTER	0.000000	0	0	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0.000000	0	0	0	0	94.00
200.00		Total (lines 50 through 199)		0	0	0	0	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0213 | Component CCN: 14-S213 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part II | Date/Time Prepared: 2/26/2018 3:14 pm

Title XIX | Subprovider - IPF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,614,141	180,422,417	0.025574	0	0	50.00
51.00	05100	RECOVERY ROOM	221,297	31,061,882	0.007124	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	552,173	9,548,582	0.057828	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,783,092	176,835,966	0.021393	0	0	54.00
54.01	05401	ULTRASOUND	348,044	30,094,812	0.011565	0	0	54.01
57.00	05700	CT SCAN	647,293	119,391,118	0.005422	0	0	57.00
58.00	05800	MRI	456,745	34,481,608	0.013246	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	624,226	176,260,164	0.003542	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	93,746	9,119,480	0.010280	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	227,899	17,551,901	0.012984	0	0	65.00
65.01	06501	SLEEP LAB	53,117	3,835,685	0.013848	0	0	65.01
66.00	06600	PHYSICAL THERAPY	146,811	9,481,468	0.015484	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	132,735	10,994,919	0.012072	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	200,195	24,199,109	0.008273	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	55,140	2,893,133	0.019059	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	960,418	45,070,622	0.021309	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	793,923	46,886,161	0.016933	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,565,677	69,361,515	0.022573	0	0	73.00
74.00	07400	RENAL DIALYSIS	138,182	3,806,579	0.036301	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	40,016	990,077	0.040417	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	1,816,954	100,003,257	0.018169	0	0	91.00
91.01	09101	OP MENTAL HEALTH	103,398	1,698,208	0.060887	0	0	91.01
91.02	09102	DIABETES CENTER	17,007	401,659	0.042342	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	13,073,620	0.000000	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0.000000	0	0	94.00
200.00		Total (lines 50 through 199)	17,592,229	1,117,463,942		0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0213 | Component CCN: 14-S213 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV Date/Time Prepared: 2/26/2018 3:14 pm

Title XIX | Subprovider - IPF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	33,689	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	7,324	65.00
65.01	06501	SLEEP LAB	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	29,294	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	0	0	675,787	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 through 199)	0	0	0	0	746,094	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0213 | Component CCN: 14-S213 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV Date/Time Prepared: 2/26/2018 3:14 pm

Title XIX | Subprovider - IPF | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	180,422,417	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	31,061,882	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	33,689	33,689	9,548,582	0.003528	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	176,835,966	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	30,094,812	0.000000	54.01
57.00	05700	CT SCAN	0	0	0	119,391,118	0.000000	57.00
58.00	05800	MRI	0	0	0	34,481,608	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	176,260,164	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	9,119,480	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	7,324	7,324	17,551,901	0.000417	65.00
65.01	06501	SLEEP LAB	0	0	0	3,835,685	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	9,481,468	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	10,994,919	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	29,294	29,294	24,199,109	0.001211	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	2,893,133	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	45,070,622	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	46,886,161	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	69,361,515	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	3,806,579	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000	89.00
90.00	09000	CLINIC	0	0	0	990,077	0.000000	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	0.000000	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	0.000000	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0	0	0.000000	90.03
91.00	09100	EMERGENCY	0	675,787	675,787	100,003,257	0.006758	91.00
91.01	09101	OP MENTAL HEALTH	0	0	0	1,698,208	0.000000	91.01
91.02	09102	DIABETES CENTER	0	0	0	401,659	0.000000	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	13,073,620	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0.000000	94.00
200.00		Total (lines 50 through 199)	0	746,094	746,094	1,117,463,942		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0213 | Component CCN: 14-S213 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV Date/Time Prepared: 2/26/2018 3:14 pm

Title XIX | Subprovider - IPF | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.003528	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	54.01
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000417	0	0	0	0	65.00
65.01	06501	SLEEP LAB	0.000000	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.001211	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	89.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	HOMER GLEN LAB	0.000000	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0.000000	0	0	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0.000000	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.006758	0	0	0	0	91.00
91.01	09101	OP MENTAL HEALTH	0.000000	0	0	0	0	91.01
91.02	09102	DIABETES CENTER	0.000000	0	0	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0.000000	0	0	0	0	94.00
200.00		Total (lines 50 through 199)		0	0	0	0	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 14-0213 | Component CCN: 14-T213 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part II | Date/Time Prepared: 2/26/2018 3:14 pm

Title XIX | Subprovider - IRF | PPS

		Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	4,614,141	180,422,417	0.025574	0	0	50.00
51.00	05100	RECOVERY ROOM	221,297	31,061,882	0.007124	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	552,173	9,548,582	0.057828	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,783,092	176,835,966	0.021393	0	0	54.00
54.01	05401	ULTRASOUND	348,044	30,094,812	0.011565	0	0	54.01
57.00	05700	CT SCAN	647,293	119,391,118	0.005422	0	0	57.00
58.00	05800	MRI	456,745	34,481,608	0.013246	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	624,226	176,260,164	0.003542	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	93,746	9,119,480	0.010280	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	227,899	17,551,901	0.012984	0	0	65.00
65.01	06501	SLEEP LAB	53,117	3,835,685	0.013848	0	0	65.01
66.00	06600	PHYSICAL THERAPY	146,811	9,481,468	0.015484	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	132,735	10,994,919	0.012072	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	200,195	24,199,109	0.008273	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	55,140	2,893,133	0.019059	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	960,418	45,070,622	0.021309	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	793,923	46,886,161	0.016933	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,565,677	69,361,515	0.022573	0	0	73.00
74.00	07400	RENAL DIALYSIS	138,182	3,806,579	0.036301	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	40,016	990,077	0.040417	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	1,816,954	100,003,257	0.018169	0	0	91.00
91.01	09101	OP MENTAL HEALTH	103,398	1,698,208	0.060887	0	0	91.01
91.02	09102	DIABETES CENTER	17,007	401,659	0.042342	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	13,073,620	0.000000	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0.000000	0	0	94.00
200.00		Total (lines 50 through 199)	17,592,229	1,117,463,942		0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0213 | Component CCN: 14-T213 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV Date/Time Prepared: 2/26/2018 3:14 pm

Title XIX | Subprovider - IRF | PPS

		Cost Center Description	Non Physician Anesthetist Cost	Nursing School Post-Stepdown Adjustments	Nursing School	Allied Health Post-Stepdown Adjustments	Allied Health	
			1.00	2A	2.00	3A	3.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	33,689	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	7,324	65.00
65.01	06501	SLEEP LAB	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	29,294	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	0	0	675,787	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 through 199)	0	0	0	0	746,094	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0213 | Component CCN: 14-T213 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV | Date/Time Prepared: 2/26/2018 3:14 pm

Title XIX | Subprovider - IRF | PPS

		Cost Center Description	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	
			4.00	5.00	6.00	7.00	8.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0	0	180,422,417	0.000000	50.00
51.00	05100	RECOVERY ROOM	0	0	0	31,061,882	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	33,689	33,689	9,548,582	0.003528	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	176,835,966	0.000000	54.00
54.01	05401	ULTRASOUND	0	0	0	30,094,812	0.000000	54.01
57.00	05700	CT SCAN	0	0	0	119,391,118	0.000000	57.00
58.00	05800	MRI	0	0	0	34,481,608	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	0	0	0	176,260,164	0.000000	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	9,119,480	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	0	7,324	7,324	17,551,901	0.000417	65.00
65.01	06501	SLEEP LAB	0	0	0	3,835,685	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	9,481,468	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	10,994,919	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0	29,294	29,294	24,199,109	0.001211	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	2,893,133	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	45,070,622	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	46,886,161	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	69,361,515	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	3,806,579	0.000000	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0.000000	89.00
90.00	09000	CLINIC	0	0	0	990,077	0.000000	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	0.000000	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	0.000000	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0	0	0.000000	90.03
91.00	09100	EMERGENCY	0	675,787	675,787	100,003,257	0.006758	91.00
91.01	09101	OP MENTAL HEALTH	0	0	0	1,698,208	0.000000	91.01
91.02	09102	DIABETES CENTER	0	0	0	401,659	0.000000	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	13,073,620	0.000000	92.00
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0.000000	94.00
200.00		Total (lines 50 through 199)	0	746,094	746,094	1,117,463,942		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 14-0213 | Component CCN: 14-T213 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D Part IV | Date/Time Prepared: 2/26/2018 3:14 pm

Title XIX | Subprovider - IRF | PPS

		Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
			9.00	10.00	11.00	12.00	13.00	
		ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0.000000	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0.000000	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.003528	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0.000000	0	0	0	0	54.01
57.00	05700	CT SCAN	0.000000	0	0	0	0	57.00
58.00	05800	MRI	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.000000	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.000417	0	0	0	0	65.00
65.01	06501	SLEEP LAB	0.000000	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.000000	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.001211	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.000000	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.000000	0	0	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS						
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	0	0	89.00
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	HOMER GLEN LAB	0.000000	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0.000000	0	0	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0.000000	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.006758	0	0	0	0	91.00
91.01	09101	OP MENTAL HEALTH	0.000000	0	0	0	0	91.01
91.02	09102	DIABETES CENTER	0.000000	0	0	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	0	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0.000000	0	0	0	0	94.00
200.00		Total (lines 50 through 199)		0	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0213 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-1 | Date/Time Prepared: 2/26/2018 3:14 pm

Title XVIII | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	68,921	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	68,921	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)	57,656	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)	26,478	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)	65,171,527	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)	65,171,527	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)	65,171,527	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)	945.60	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	25,037,597	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)	25,037,597	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0213 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-1 | Date/Time Prepared: 2/26/2018 3:14 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	15,579,719	8,011	1,944.79	3,768	7,327,969	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)	40,900,645	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	73,266,211	49.00
	PASS THROUGH COST ADJUSTMENTS		
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)	2,812,751	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	2,973,309	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	5,786,060	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	67,480,151	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	11,265	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	945.60	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	10,652,184	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0213 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-1 | Date/Time Prepared: 2/26/2018 3:14 pm

Title XVIII | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	5,737,985	65,171,527	0.088044	10,652,184	937,861	90.00
91.00	Nursing School cost	0	65,171,527	0.000000	10,652,184	0	91.00
92.00	Allied health cost	0	65,171,527	0.000000	10,652,184	0	92.00
93.00	All other Medical Education	0	65,171,527	0.000000	10,652,184	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-0213 Component CCN: 14-S213	Period: From 10/01/2016 To 09/30/2017	Worksheet D-1 Date/Time Prepared: 2/26/2018 3:14 pm
	Title XVIII	Subprovider - IPF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	6,051	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	6,051	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)	6,051	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)	1,224	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	0	15.00
16.00	Nursery days (title V or XIX only)	0	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,831,392	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,831,392	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	4,831,392	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)	798.45	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	977,303	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)	977,303	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0213 | Component CCN: 14-S213 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-1 | Date/Time Prepared: 2/26/2018 3:14 pm

Title XVIII | Subprovider - IPF | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	86,335	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	1,063,638	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)	93,330	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	7,845	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	101,175	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	962,463	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 10/01/2016 To 09/30/2017	Worksheet D-1 Date/Time Prepared: 2/26/2018 3:14 pm
	Title XVIII	Subprovider - IPF	PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	461,383	4,831,392	0.095497	0	0	90.00
91.00	Nursing School cost	0	4,831,392	0.000000	0	0	91.00
92.00	Allied health cost	0	4,831,392	0.000000	0	0	92.00
93.00	All other Medical Education	0	4,831,392	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-0213 Component CCN: 14-T213	Period: From 10/01/2016 To 09/30/2017	Worksheet D-1 Date/Time Prepared: 2/26/2018 3:14 pm
	Title XVIII	Subprovider - IRF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	7,859	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	7,859	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	7,859	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)	5,243	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)	9,398,696	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	9,398,696	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)	9,398,696	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)	1,195.92	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	6,270,209	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)	6,270,209	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0213 | Component CCN: 14-T213 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-1 | Date/Time Prepared: 2/26/2018 3:14 pm

Title XVIII | Subprovider - IRF | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	2,486,551	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	8,756,760	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)	583,074	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	116,473	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)	699,547	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	8,057,213	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 10/01/2016 To 09/30/2017	Worksheet D-1 Date/Time Prepared: 2/26/2018 3:14 pm
	Title XVIII	Subprovider - IRF	PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	873,984	9,398,696	0.092990	0	0	90.00
91.00	Nursing School cost	0	9,398,696	0.000000	0	0	91.00
92.00	Allied health cost	0	9,398,696	0.000000	0	0	92.00
93.00	All other Medical Education	0	9,398,696	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0213 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-1 | Date/Time Prepared: 2/26/2018 3:14 pm

Title XIX | Hospital | PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	68,921	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	68,921	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)	57,656	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)	4,255	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)	7,132	15.00
16.00	Nursery days (title V or XIX only)	526	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)	65,171,527	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)	65,171,527	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)	65,171,527	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)	945.60	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	4,023,528	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)	4,023,528	41.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0213 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-1 | Date/Time Prepared: 2/26/2018 3:14 pm

Title XIX | Hospital | PPS

	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	8,600,018	7,132	1,205.84	526	634,272	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	15,579,719	8,011	1,944.79	591	1,149,371	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT						45.00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	5,807,171	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)	560,419	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)	560,419	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	5,246,752	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION		
54.00	Program discharges	0	54.00
55.00	Target amount per discharge	0.00	55.00
56.00	Target amount (line 54 x line 55)	0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)	0	57.00
58.00	Bonus payment (see instructions)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket	0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)	0	61.00
62.00	Relief payment (see instructions)	0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)	0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)	0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)	0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY		
70.00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72.00	Program routine service cost (line 9 x line 71)		72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)		73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)		76.00
77.00	Program capital-related costs (line 9 x line 76)		77.00
78.00	Inpatient routine service cost (line 74 minus line 77)		78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation		81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)		82.00
83.00	Reasonable inpatient routine service costs (see instructions)		83.00
84.00	Program inpatient ancillary services (see instructions)		84.00
85.00	Utilization review - physician compensation (see instructions)		85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)		86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		
87.00	Total observation bed days (see instructions)	11,265	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)	945.60	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)	10,652,184	89.00

COMPUTATION OF INPATIENT OPERATING COST | Provider CCN: 14-0213 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-1 | Date/Time Prepared: 2/26/2018 3:14 pm

Title XIX | Hospital | PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	5,737,985	65,171,527	0.088044	10,652,184	937,861	90.00
91.00	Nursing School cost	0	65,171,527	0.000000	10,652,184	0	91.00
92.00	Allied health cost	0	65,171,527	0.000000	10,652,184	0	92.00
93.00	All other Medical Education	0	65,171,527	0.000000	10,652,184	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-0213 Component CCN: 14-S213	Period: From 10/01/2016 To 09/30/2017	Worksheet D-1 Date/Time Prepared: 2/26/2018 3:14 pm
	Title XIX	Subprovider - IPF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	6,051	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	6,051	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)	6,051	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)	816	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)	7,132	15.00
16.00	Nursery days (title V or XIX only)	526	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period	0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)	4,831,392	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4,831,392	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28.00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)	0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)	0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	4,831,392	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)	798.45	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	651,535	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)	651,535	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0213 | Component CCN: 14-S213 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-1 | Date/Time Prepared: 2/26/2018 3:14 pm

Title XIX | Subprovider - IPF | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	651,535	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)	62,220	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)	62,220	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	589,315	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 10/01/2016 To 09/30/2017	Worksheet D-1 Date/Time Prepared: 2/26/2018 3:14 pm
	Title XIX	Subprovider - IPF	PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	461,383	4,831,392	0.095497	0	0	90.00
91.00	Nursing School cost	0	4,831,392	0.000000	0	0	91.00
92.00	Allied health cost	0	4,831,392	0.000000	0	0	92.00
93.00	All other Medical Education	0	4,831,392	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 14-0213 Component CCN: 14-T213	Period: From 10/01/2016 To 09/30/2017	Worksheet D-1 Date/Time Prepared: 2/26/2018 3:14 pm
	Title XIX	Subprovider - IRF	PPS

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS		
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	7,859	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	7,859	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)	7,859	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)	101	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)	7,132	15.00
16.00	Nursery days (title V or XIX only)	526	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)	9,398,696	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25.00
26.00	Total swing-bed cost (see instructions)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	9,398,696	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)	9,398,696	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)	1,195.92	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)	120,788	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)	120,788	41.00

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 14-0213 | Component CCN: 14-T213 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-1 | Date/Time Prepared: 2/26/2018 3:14 pm

Title XIX | Subprovider - IRF | PPS

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

	Cost Center Description		
		1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	0	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)	120,788	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)	11,232	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)	11,232	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	109,556	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 10/01/2016 To 09/30/2017	Worksheet D-1 Date/Time Prepared: 2/26/2018 3:14 pm
	Title XIX	Subprovider - IRF	PPS

	Cost Center Description	Cost	Routine Cost (from line 21)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
	COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
90.00	Capital-related cost	873,984	9,398,696	0.092990	0	0	90.00
91.00	Nursing School cost	0	9,398,696	0.000000	0	0	91.00
92.00	Allied health cost	0	9,398,696	0.000000	0	0	92.00
93.00	All other Medical Education	0	9,398,696	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT | Provider CCN: 14-0213 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-3 | Date/Time Prepared: 2/26/2018 3:14 pm

Title XVIII | Hospital | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		30,212,937		30.00
31.00	03100	INTENSIVE CARE UNIT		10,526,746		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	0.210583	21,493,757	4,526,220	50.00
51.00	05100	RECOVERY ROOM	0.086519	4,152,427	359,264	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.756015	26,072	19,711	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.156998	18,543,341	2,911,267	54.00
54.01	05401	ULTRASOUND	0.089724	4,307,615	386,496	54.01
57.00	05700	CT SCAN	0.034015	17,144,764	583,179	57.00
58.00	05800	MRI	0.073543	4,760,240	350,082	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.084003	29,115,093	2,445,755	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.287046	2,490,830	714,983	63.00
65.00	06500	RESPIRATORY THERAPY	0.214558	6,754,131	1,449,153	65.00
65.01	06501	SLEEP LAB	0.180855	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.362352	3,419,526	1,239,072	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.331566	1,848,685	612,961	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.108574	6,412,992	696,284	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.236053	385,782	91,065	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.444169	18,808,291	8,354,060	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.531923	13,063,464	6,948,757	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.349548	15,399,860	5,382,990	73.00
74.00	07400	RENAL DIALYSIS	0.294081	2,108,790	620,155	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	1.128503	137	155	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	0.197161	13,171,916	2,596,988	91.00
91.01	09101	OP MENTAL HEALTH	0.590091	0	0	91.01
91.02	09102	DIABETES CENTER	1.194020	18,447	22,026	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.814785	724,144	590,022	92.00
		OTHER REIMBURSABLE COST CENTERS				
94.00	09400	HOME PROGRAM DIALYSIS	0.000000	0	0	94.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		184,150,304	40,900,645	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)		184,150,304		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-0213 | Component CCN: 14-S213 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-3 | Date/Time Prepared: 2/26/2018 3:14 pm

Title XVIII | Subprovider - IPF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		1,376,755		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	0.210583	3,577	753	50.00
51.00	05100	RECOVERY ROOM	0.086519	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.756015	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.156998	10,223	1,605	54.00
54.01	05401	ULTRASOUND	0.089724	12,617	1,132	54.01
57.00	05700	CT SCAN	0.034015	23,763	808	57.00
58.00	05800	MRI	0.073543	6,137	451	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.084003	260,686	21,898	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.287046	6,654	1,910	63.00
65.00	06500	RESPIRATORY THERAPY	0.214558	14,364	3,082	65.00
65.01	06501	SLEEP LAB	0.180855	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.362352	5,184	1,878	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.331566	2,945	976	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.108574	10,568	1,147	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.236053	625	148	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.444169	2,566	1,140	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.531923	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.349548	21,069	7,365	73.00
74.00	07400	RENAL DIALYSIS	0.294081	0	0	74.00
		OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000	CLINIC	1.128503	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	0.197161	208,812	41,170	91.00
91.01	09101	OP MENTAL HEALTH	0.590091	0	0	91.01
91.02	09102	DIABETES CENTER	1.194020	730	872	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.814785	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
94.00	09400	HOME PROGRAM DIALYSIS	0.000000	0	0	94.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		590,520	86,335	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)		590,520		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 14-0213 | Component CCN: 14-T213 | Period: From 10/01/2016 To 09/30/2017 | Worksheet D-3 | Date/Time Prepared: 2/26/2018 3:14 pm

Title XVIII | Subprovider - IRF | PPS

		Cost Center Description	Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2.00	3.00	
		INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		0		30.00
31.00	03100	INTENSIVE CARE UNIT		0		31.00
40.00	04000	SUBPROVIDER - IPF		0		40.00
41.00	04100	SUBPROVIDER - IRF		5,454,287		41.00
42.00	04200	SUBPROVIDER		0		42.00
43.00	04300	NURSERY				43.00
		ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.210583	90,999	19,163	50.00
51.00	05100	RECOVERY ROOM	0.086519	1,393	121	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.756015	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.156998	125,259	19,665	54.00
54.01	05401	ULTRASOUND	0.089724	120,994	10,856	54.01
57.00	05700	CT SCAN	0.034015	224,965	7,652	57.00
58.00	05800	MRI	0.073543	59,986	4,412	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000	LABORATORY	0.084003	1,186,933	99,706	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.287046	67,468	19,366	63.00
65.00	06500	RESPIRATORY THERAPY	0.214558	306,600	65,783	65.00
65.01	06501	SLEEP LAB	0.180855	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0.362352	2,697,792	977,550	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.331566	2,512,256	832,979	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.108574	44,729	4,856	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.236053	10,543	2,489	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.444169	437,357	194,260	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.531923	2,236	1,189	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.349548	527,586	184,417	73.00
74.00	07400	RENAL DIALYSIS	0.294081	136,862	40,249	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	1.128503	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	0.197161	476	94	91.00
91.01	09101	OP MENTAL HEALTH	0.590091	0	0	91.01
91.02	09102	DIABETES CENTER	1.194020	1,461	1,744	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.814785	0	0	92.00
		OTHER REIMBURSABLE COST CENTERS				
94.00	09400	HOME PROGRAM DIALYSIS	0.000000	0	0	94.00
200.00		Total (sum of lines 50 through 94 and 96 through 98)		8,555,895	2,486,551	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)		8,555,895		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0213	Period: From 10/01/2016 To 09/30/2017	Worksheet E Part A Date/Time Prepared: 2/26/2018 3:14 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		
1.00	DRG Amounts Other than Outlier Payments	0	1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)	0	1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)	57,742,313	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)	853,618	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	13,263,667	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)	226.14	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 § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.	0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.	0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)	0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records	0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.	0.00	11.00
12.00	Current year allowable FTE (see instructions)	0.00	12.00
13.00	Total allowable FTE count for the prior year.	0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.	0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.	0.00	15.00
16.00	Adjustment for residents in initial years of the program	0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure	0.00	17.00
18.00	Adjusted rolling average FTE count	0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).	0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)	0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)	0.000000	21.00
22.00	IME payment adjustment (see instructions)	0	22.00
22.01	IME payment adjustment - Managed Care (see instructions)	0	22.01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA		
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).	0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)	0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)	0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)	0.000000	26.00
27.00	IME payments adjustment factor. (see instructions)	0.000000	27.00
28.00	IME add-on adjustment amount (see instructions)	0	28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)	0	28.01
29.00	Total IME payment (sum of lines 22 and 28)	0	29.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)	0	29.01
	Disproportionate Share Adjustment		
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)	2.17	30.00
31.00	Percentage of Medicaid patient days (see instructions)	15.04	31.00
32.00	Sum of lines 30 and 31	17.21	32.00
33.00	Allowable disproportionate share percentage (see instructions)	3.94	33.00
34.00	Disproportionate share adjustment (see instructions)	568,762	34.00

CALCULATION OF REIMBURSEMENT SETTLEMENT | Provider CCN: 14-0213 | Period: From 10/01/2016 To 09/30/2017 | Worksheet E Part A Date/Time Prepared: 2/26/2018 3:14 pm

Title XVIII | Hospital | PPS

		Prior to 10/1	On/After 10/1	
		1.00	2.00	
	Uncompensated Care Adjustment			
35.00	Total uncompensated care amount (see instructions)	0	5,977,483,147	35.00
35.01	Factor 3 (see instructions)	0.000000000	0.000279419	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)	0	1,670,224	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)	0	1,670,224	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)	1,670,224		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)	60,834,917		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)		60,834,917	49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		5,038,840	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		71,352	53.00
54.00	Special add-on payments for new technologies		6,214	54.00
54.01	Islet isolation add-on payment		0	54.01
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0	55.00
56.00	Cost of physicians' services in a teaching hospital (see intructions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		13,791	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		99,690	58.00
59.00	Total (sum of amounts on lines 49 through 58)		66,064,804	59.00
60.00	Primary payer payments		28,086	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		66,036,718	61.00
62.00	Deductibles billed to program beneficiaries		6,246,828	62.00
63.00	Coinsurance billed to program beneficiaries		157,073	63.00
64.00	Allowable bad debts (see instructions)		930,184	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		604,620	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		477,245	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		60,237,437	67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0	68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96).(For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.50	Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)		0	70.50
70.87	Demonstration payment adjustment amount before sequestration		0	70.87
70.88	SCH or MDH volume decrease adjustment (contractor use only)		0	70.88
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		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)		553,735	70.93
70.94	HRR adjustment amount (see instructions)		-970,174	70.94
70.95	Recovery of accelerated depreciation		0	70.95

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0213	Period: From 10/01/2016 To 09/30/2017	Worksheet E Part A Date/Time Prepared: 2/26/2018 3:14 pm
	Title XVIII	Hospital	PPS

		FFY (yyyy)	Amount	
		0	1.00	
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0	70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70.97
70.98	Low Volume Payment-3		0	70.98
70.99	HAC adjustment amount (see instructions)		0	70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		59,820,998	71.00
71.01	Sequestration adjustment (see instructions)		1,196,420	71.01
71.02	Demonstration payment adjustment amount after sequestration		0	71.02
72.00	Interim payments		58,498,863	72.00
73.00	Tentative settlement (for contractor use only)		0	73.00
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		125,715	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		1,136,774	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
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment			
200.00	Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.			200.00
	Cost Reimbursement			
201.00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201.00
202.00	Medicare discharges (see instructions)			202.00
203.00	Case-mix adjustment factor (see instructions)			203.00
	Computation of Demonstration Target Amount Limitation (N/A in first year of the current 5-year demonstration period)			
204.00	Medicare target amount			204.00
205.00	Case-mix adjusted target amount (line 203 times line 204)			205.00
206.00	Medicare inpatient routine cost cap (line 202 times line 205)			206.00
	Adjustment to Medicare Part A Inpatient Reimbursement			
207.00	Program reimbursement under the §410A Demonstration (see instructions)			207.00
208.00	Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208.00
209.00	Adjustment to Medicare IPPS payments (see instructions)			209.00
210.00	Reserved for future use			210.00
211.00	Total adjustment to Medicare IPPS payments (line 209 plus line 210) (see instructions)			211.00
	Comparision of PPS versus Cost Reimbursement			
212.00	Total adjustment to Medicare Part A IPPS payments (from line 211)			212.00
213.00	Low-volume adjustment (see instructions)			213.00
218.00	Net Medicare Part A IPPS adjustment (difference between PPS and cost reimbursement) (line 212 minus line 213) (see instructions)			218.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 14-0213 | Period: From 10/01/2016 To 09/30/2017 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 2/26/2018 3:14 pm

Title XVIII | Hospital | PPS

		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	57,742,313		57,742,313	57,742,313	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	853,618	0	853,618	853,618	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	13,263,667	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	0.0394	0.0394	0.0394		10.00
11.00	Disproportionate share adjustment (see instructions)	34.00	568,762	0	568,762	568,762	11.00
11.01	Uncompensated care payments	36.00	1,670,224	0	1,670,224	1,670,224	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	60,834,917	0	60,834,917	60,834,917	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	60,834,917	0	60,834,917	60,834,917	15.00
16.00	Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)	50.00	5,038,840	0	5,038,840	5,038,840	16.00
17.00	Special add-on payments for new technologies	54.00	6,214	0	6,214	6,214	17.00
17.01	Net organ acquisition cost						17.01
17.02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	0	0	18.00
19.00	SUBTOTAL			0	65,879,971	65,879,971	19.00

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5 | Provider CCN: 14-0213 | Period: From 10/01/2016 To 09/30/2017 | Worksheet E Part A Exhibit 5 Date/Time Prepared: 2/26/2018 3:14 pm

Title XVIII | Hospital | PPS

		Wkst. L, line	(Amt. from Wkst. L)				
		0	1.00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	4,674,444	0	4,674,444	4,674,444	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	198,453	0	198,453	198,453	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	0.0355	0.0355	0.0355		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	165,943	0	165,943	165,943	25.00
26.00	Total prospective capital payments (see instructions)	12.00	5,038,840	0	5,038,840	5,038,840	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	553,735	0	553,735	553,735	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	-970,174	0	-970,174	-970,174	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 10/01/2016 To 09/30/2017	Worksheet E Part B Date/Time Prepared: 2/26/2018 3:14 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		
1.00	Medical and other services (see instructions)	56,087	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)	31,557,676	2.00
3.00	OPPS payments	29,638,262	3.00
4.00	Outlier payment (see instructions)	111,980	4.00
4.01	Outlier reconciliation amount (see instructions)	0	4.01
5.00	Enter the hospital specific payment to cost ratio (see instructions)	0.000	5.00
6.00	Line 2 times line 5	0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6	0.00	7.00
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	83,108	9.00
10.00	Organ acquisitions	0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)	56,087	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES		
	Reasonable charges		
12.00	Ancillary service charges	124,479	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)	124,479	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)	124,479	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	68,392	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) (see instructions)	56,087	21.00
22.00	Interns and residents (see instructions)	0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)	0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	29,833,350	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00	Deductibles and coinsurance (for CAH, see instructions)	13,792	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	5,675,681	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)	24,199,964	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)	24,199,964	30.00
31.00	Primary payer payments	12,063	31.00
32.00	Subtotal (line 30 minus line 31)	24,187,901	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)	588,172	34.00
35.00	Adjusted reimbursable bad debts (see instructions)	382,312	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	333,537	36.00
37.00	Subtotal (see instructions)	24,570,213	37.00
38.00	MSP-LCC reconciliation amount from PS&R	-245	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
39.97	Demonstration payment adjustment amount before sequestration	0	39.97
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)	0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION	0	39.99
40.00	Subtotal (see instructions)	24,570,458	40.00
40.01	Sequestration adjustment (see instructions)	491,409	40.01
40.02	Demonstration payment adjustment amount after sequestration	0	40.02
41.00	Interim payments	23,880,614	41.00
42.00	Tentative settlement (for contractors use only)	0	42.00
43.00	Balance due provider/program (see instructions)	198,435	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	516,278	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 10/01/2016 To 09/30/2017 | Worksheet E-1 Part I | Date/Time Prepared: 2/26/2018 3:14 pm

Title XVIII | Hospital | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		58,459,272		23,880,614	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	05/04/2017	39,591		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)		39,591		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)		58,498,863		23,880,614	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		125,715		198,435	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		58,624,578		24,079,049	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 10/01/2016 To 09/30/2017 | Worksheet E-1 Part I | Date/Time Prepared: 2/26/2018 3:14 pm

Title XVIII | Subprovider - IPF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		951,538		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)		951,538		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		86,039		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		1,037,577		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 10/01/2016 To 09/30/2017 | Worksheet E-1 Part I | Date/Time Prepared: 2/26/2018 3:14 pm

Title XVIII | Subprovider - IRF | PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		8,103,578		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)		8,103,578		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		12,889		0	6.02
7.00	Total Medicare program liability (see instructions)		8,090,689		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 10/01/2016 To 09/30/2017	Worksheet E-1 Part II Date/Time Prepared: 2/26/2018 3:14 pm
	Title XVIII	Hospital	PPS

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

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0213 Component CCN: 14-S213	Period: From 10/01/2016 To 09/30/2017	Worksheet E-3 Part II Date/Time Prepared: 2/26/2018 3:14 pm
	Title XVIII	Subprovider - IPF	PPS

		1.00	
	PART II - MEDICARE PART A SERVICES - IPF PPS		
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	1,104,918	1.00
2.00	Net IPF PPS Outlier Payments	0	2.00
3.00	Net IPF PPS ECT Payments	0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)	0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	4.01
5.00	New Teaching program adjustment. (see instructions)	0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instuctions)	0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instuctions)	0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.00	8.00
9.00	Average Daily Census (see instructions)	16.578082	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)	1,104,918	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)	1,104,918	16.00
17.00	Primary payer payments	2,555	17.00
18.00	Subtotal (line 16 less line 17).	1,102,363	18.00
19.00	Deductibles	117,796	19.00
20.00	Subtotal (line 18 minus line 19)	984,567	20.00
21.00	Coinsurance	13,608	21.00
22.00	Subtotal (line 20 minus line 21)	970,959	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	132,866	23.00
24.00	Adjusted reimbursable bad debts (see instructions)	86,363	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	82,153	25.00
26.00	Subtotal (sum of lines 22 and 24)	1,057,322	26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	27.00
28.00	Other pass through costs (see instructions)	1,430	28.00
29.00	Outlier payments reconciliation	0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	30.50
30.99	Demonstration payment adjustment amount before sequestration	0	30.99
31.00	Total amount payable to the provider (see instructions)	1,058,752	31.00
31.01	Sequestration adjustment (see instructions)	21,175	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	31.02
32.00	Interim payments	951,538	32.00
33.00	Tentative settlement (for contractor use only)	0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)	86,039	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	8,010	35.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	0	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)	0	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	52.00
53.00	Time Value of Money (see instructions)	0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 14-0213 Component CCN: 14-T213	Period: From 10/01/2016 To 09/30/2017	Worksheet E-3 Part III Date/Time Prepared: 2/26/2018 3:14 pm
	Title XVIII	Subprovider - IRF	PPS

		1.00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
1.00	Net Federal PPS Payment (see instructions)	7,909,613	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0.0090	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	69,605	3.00
4.00	Outlier Payments	344,430	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)	21.531507	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)	8,323,648	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)	8,323,648	17.00
18.00	Primary payer payments	0	18.00
19.00	Subtotal (line 17 less line 18).	8,323,648	19.00
20.00	Deductibles	24,780	20.00
21.00	Subtotal (line 19 minus line 20)	8,298,868	21.00
22.00	Coinsurance	45,304	22.00
23.00	Subtotal (line 21 minus line 22)	8,253,564	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	3,163	24.00
25.00	Adjusted reimbursable bad debts (see instructions)	2,056	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	26.00
27.00	Subtotal (sum of lines 23 and 25)	8,255,620	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)	185	29.00
30.00	Outlier payments reconciliation	0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	31.50
31.99	Demonstration payment adjustment amount before sequestration	0	31.99
32.00	Total amount payable to the provider (see instructions)	8,255,805	32.00
32.01	Sequestration adjustment (see instructions)	165,116	32.01
32.02	Demonstration payment adjustment amount after sequestration	0	32.02
33.00	Interim payments	8,103,578	33.00
34.00	Tentative settlement (for contractor use only)	0	34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)	-12,889	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	36.00
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4	344,430	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 10/01/2016 To 09/30/2017 | Worksheet G | Date/Time Prepared: 2/26/2018 3:14 pm

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	31,165,000	0	0	0	1.00
2.00	Temporary investments	2,235,000	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	46,226,000	0	0	0	4.00
5.00	Other receivable	1,008,000	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	6,082,000	0	0	0	8.00
9.00	Other current assets	9,882,000	0	0	0	9.00
10.00	Due from other funds	39,079,000	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	135,677,000	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	631,180,814	0	0	0	15.00
16.00	Accumulated depreciation	-216,802,814	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)	414,378,000	0	0	0	30.00
	OTHER ASSETS					
31.00	Investments	181,848,000	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	33,659,000	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	215,507,000	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	765,562,000	0	0	0	36.00
	CURRENT LIABILITIES					
37.00	Accounts payable	25,549,000	0	0	0	37.00
38.00	Salaries, wages, and fees payable	16,114,000	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	7,305,000	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0				42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	43,026,000	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	91,994,000	0	0	0	45.00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	399,913,000	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	6,006,000	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	405,919,000	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	497,913,000	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	267,649,000				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)	267,649,000	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	765,562,000	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES | Provider CCN: 14-0213 | Period: From 10/01/2016 To 09/30/2017 | Worksheet G-1 | Date/Time Prepared: 2/26/2018 3:14 pm

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		233,479,000		0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		32,915,096				2.00
3.00	Total (sum of line 1 and line 2)		266,394,096		0		3.00
4.00	PERMANENTLY RESTRICED ASSETS	363,000		0		0	4.00
5.00	INCREASE UNRESTRICTED ASSETS	2,007,904		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		2,370,904		0		10.00
11.00	Subtotal (line 3 plus line 10)		268,765,000		0		11.00
12.00	DECREASE IN TEMPORARILY RESTRICTED A	1,116,000		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)		1,116,000		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		267,649,000		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	PERMANENTLY RESTRICED ASSETS		0		4.00
5.00	INCREASE UNRESTRICTED ASSETS		0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	DECREASE IN TEMPORARILY RESTRICTED A		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 10/01/2016 To 09/30/2017 | Worksheet G-2 Parts I & II Date/Time Prepared: 2/26/2018 3:14 pm

	Cost Center Description	Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospital	77,712,876		77,712,876	1.00
2.00	SUBPROVIDER - IPF	6,807,290		6,807,290	2.00
3.00	SUBPROVIDER - IRF	16,092,475		16,092,475	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)	100,612,641		100,612,641	10.00
	Intensive Care Type Inpatient Hospital Services				
11.00	INTENSIVE CARE UNIT	21,437,671		21,437,671	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)	21,437,671		21,437,671	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	122,050,312		122,050,312	17.00
18.00	Ancillary services	422,767,356	556,447,046	979,214,402	18.00
19.00	Outpatient services	29,497,456	73,761,002	103,258,458	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		5,673,989	5,673,989	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC		0	0	24.00
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	NURSERY	10,020,732	0	10,020,732	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	584,335,856	635,882,037	1,220,217,893	28.00
	PART II - OPERATING EXPENSES				
29.00	Operating expenses (per Wkst. A, column 3, line 200)		363,221,817		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)		363,221,817		43.00

STATEMENT OF REVENUES AND EXPENSES	Provider CCN: 14-0213	Period: From 10/01/2016 To 09/30/2017	Worksheet G-3 Date/Time Prepared: 2/26/2018 3:14 pm

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	1,220,217,893	1.00
2.00	Less contractual allowances and discounts on patients' accounts	834,843,220	2.00
3.00	Net patient revenues (line 1 minus line 2)	385,374,673	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	363,221,817	4.00
5.00	Net income from service to patients (line 3 minus line 4)	22,152,856	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	10,274,240	24.00
24.01	NON-OPERATING INCOME	488,000	24.01
25.00	Total other income (sum of lines 6-24)	10,762,240	25.00
26.00	Total (line 5 plus line 25)	32,915,096	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)	32,915,096	29.00

ANALYSIS OF HOSPITAL-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 14-0213 | HHA CCN: 14-7452 | Period: From 10/01/2016 To 09/30/2017 | Worksheet H | Date/Time Prepared: 2/26/2018 3:14 pm

Home Health Agency I | PPS

		Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of cols. 1 thru 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures			0		0	0	1.00
2.00	Capital Related - Movable Equipment			0		0	0	2.00
3.00	Plant Operation & Maintenance	0	0	0	0	0	0	3.00
4.00	Transportation	0	0	0	0	0	0	4.00
5.00	Administrative and General	604,897	0	0	649	45,698	651,244	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	156,802	156,802	6.00
7.00	Physical Therapy	0	0	0	962,497	0	962,497	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	1,243,091	0	0	0	0	1,243,091	10.00
11.00	Home Health Aide	45,433	0	7,693	0	0	53,126	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)	1,893,421	0	7,693	963,146	202,500	3,066,760	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	686,244	0	686,244			5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	156,802	0	156,802			6.00
7.00	Physical Therapy	-27,217	935,280	0	935,280			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	1,243,091	0	1,243,091			10.00
11.00	Home Health Aide	0	53,126	0	53,126			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)	7,783	3,074,543	0	3,074,543			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 10/01/2016 To 09/30/2017 | Worksheet H-1 Part I | Date/Time Prepared: 2/26/2018 3:14 pm

Home Health Agency I | PPS

		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	686,244	0	0	0	0	686,244	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	156,802	0	0	0	0	156,802	6.00
7.00	Physical Therapy	935,280	0	0	0	0	935,280	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	1,243,091	0	0	0	0	1,243,091	10.00
11.00	Home Health Aide	53,126	0	0	0	0	53,126	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)	3,074,543	0	0	0	0	3,074,543	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	686,244			5.00
	HHA REIMBURSABLE SERVICES				
6.00	Skilled Nursing Care	45,055	201,857		6.00
7.00	Physical Therapy	268,740	1,204,020		7.00
8.00	Occupational Therapy	0	0		8.00
9.00	Speech Pathology	0	0		9.00
10.00	Medical Social Services	357,184	1,600,275		10.00
11.00	Home Health Aide	15,265	68,391		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)		3,074,543		24.00

COST ALLOCATION - HHA STATISTICAL BASIS | Provider CCN: 14-0213 | HHA CCN: 14-7452 | Period: From 10/01/2016 To 09/30/2017 | Worksheet H-1 Part II Date/Time Prepared: 2/26/2018 3:14 pm

Home Health Agency I | PPS

		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	-686,244	2,388,299	5.00
	HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	156,802	6.00
7.00	Physical Therapy	0	0	0	0	0	935,280	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	1,243,091	10.00
11.00	Home Health Aide	0	0	0	0	0	53,126	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	-686,244	2,388,299	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		686,244	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.287336	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

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

Period: From 10/01/2016 To 09/30/2017

Worksheet H-2 Part I Date/Time Prepared: 2/26/2018 3:14 pm

Home Health Agency I

PPS

	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	1,393	545,462	546,855	131,390	1.00
2.00	Skilled Nursing Care	201,857	0	0	0	201,857	48,499	2.00
3.00	Physical Therapy	1,204,020	0	0	0	1,204,020	289,284	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	1,600,275	0	0	0	1,600,275	384,490	6.00
7.00	Home Health Aide	68,391	0	0	0	68,391	16,432	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)	3,074,543	0	1,393	545,462	3,621,398	870,095	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	194,366	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	194,366	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 10/01/2016 To 09/30/2017 | Worksheet H-2 Part I | Date/Time Prepared: 2/26/2018 3:14 pm

Home Health Agency I | PPS

	Cost Center Description	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	PARAMED ED PRGM	Subtotal	
		14.00	15.00	16.00	17.00	23.00	24.00	
1.00	Administrative and General	7,656	0	0	0	0	880,267	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	250,356	2.00
3.00	Physical Therapy	0	0	0	0	0	1,493,304	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	1,984,765	6.00
7.00	Home Health Aide	0	0	0	0	0	84,823	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)	7,656	0	0	0	0	4,693,515	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	880,267					1.00
2.00	Skilled Nursing Care	0	250,356	57,793	308,149			2.00
3.00	Physical Therapy	0	1,493,304	344,720	1,838,024			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	1,984,765	458,173	2,442,938			6.00
7.00	Home Health Aide	0	84,823	19,581	104,404			7.00
8.00	Supplies (see instructions)	0	0	0	0			8.00
9.00	Drugs	0	0	0	0			9.00
10.00	DME	0	0	0	0			10.00
11.00	Home Dialysis Aide Services	0	0	0	0			11.00
12.00	Respiratory Therapy	0	0	0	0			12.00
13.00	Private Duty Nursing	0	0	0	0			13.00
14.00	Clinic	0	0	0	0			14.00
15.00	Health Promotion Activities	0	0	0	0			15.00
16.00	Day Care Program	0	0	0	0			16.00
17.00	Home Delivered Meals Program	0	0	0	0			17.00
18.00	Homemaker Service	0	0	0	0			18.00
19.00	All Others (specify)	0	0	0	0			19.00
19.50	Telemedicine	0	0	0	0			19.50
20.00	Total (sum of lines 1-19) (2)	0	4,693,515	880,267	4,693,515			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.			0.230844				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 10/01/2016 To 09/30/2017

Worksheet H-2 Part II Date/Time Prepared: 2/26/2018 3:14 pm

Home Health Agency I

PPS

	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	1,893,421	0	546,855	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	201,857	0	2.00
3.00	Physical Therapy	0	0	0	0	1,204,020	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	1,600,275	0	6.00
7.00	Home Health Aide	0	0	0	0	68,391	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	1,893,421		3,621,398	0	20.00
21.00	Total cost to be allocated	0	1,393	545,462		870,095	0	21.00
22.00	Unit cost multiplier	0.000000	1.167645	0.288083		0.240265	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	48,256	70,766	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	48,256	70,766	20.00
21.00	Total cost to be allocated	0	0	0	0	194,366	7,656	21.00
22.00	Unit cost multiplier	0.000000	0.000000	0.000000	0.000000	4.027810	0.108188	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

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

Period:
From 10/01/2016
To 09/30/2017

Worksheet H-2
Part II
Date/Time Prepared:
2/26/2018 3:14 pm

Home Health Agency I

PPS

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

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 14-0213 | HHA CCN: 14-7452 | Period: From 10/01/2016 To 09/30/2017 | Worksheet H-3 Part I | Date/Time Prepared: 2/26/2018 3:14 pm

Title XVIII | Home Health Agency I | PPS

	Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (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	308,149		308,149	12,126	25.41	1.00
2.00	Physical Therapy	3.00	1,838,024	0	1,838,024	7,934	231.66	2.00
3.00	Occupational Therapy	4.00	0	0	0	2,387	0.00	3.00
4.00	Speech Pathology	5.00	0	0	0	334	0.00	4.00
5.00	Medical Social Services	6.00	2,442,938		2,442,938	104	23,489.79	5.00
6.00	Home Health Aide	7.00	104,404		104,404	1,255	83.19	6.00
7.00	Total (sum of lines 1-6)		4,693,515	0	4,693,515	24,140		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	8,791			8.00
9.00	Physical Therapy		16974	0	5,636			9.00
10.00	Occupational Therapy		16974	0	1,686			10.00
11.00	Speech Pathology		16974	0	230			11.00
12.00	Medical Social Services		16974	0	84			12.00
13.00	Home Health Aide		16974	0	1,030			13.00
14.00	Total (sum of lines 8-13)			0	17,457			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	8,791		0	223,379		1.00
2.00	Physical Therapy	0	5,636		0	1,305,636		2.00
3.00	Occupational Therapy	0	1,686		0	0		3.00
4.00	Speech Pathology	0	230		0	0		4.00
5.00	Medical Social Services	0	84		0	1,973,142		5.00
6.00	Home Health Aide	0	1,030		0	85,686		6.00
7.00	Total (sum of lines 1-6)	0	17,457		0	3,587,843		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 10/01/2016 To 09/30/2017 | Worksheet H-3 Part I | Date/Time Prepared: 2/26/2018 3:14 pm

Title XVIII | Home Health Agency I | PPS

	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	223,379	1.00
2.00	Physical Therapy	1,305,636	2.00
3.00	Occupational Therapy	0	3.00
4.00	Speech Pathology	0	4.00
5.00	Medical Social Services	1,973,142	5.00
6.00	Home Health Aide	85,686	6.00
7.00	Total (sum of lines 1-6)	3,587,843	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 10/01/2016 To 09/30/2017 | Worksheet H-3 Part II | Date/Time Prepared: 2/26/2018 3:14 pm

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	0.362352	0	0	col. 2, line 2.00		1.00
2.00	Occupational Therapy	67.00	0.331566	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	0.444169	0	0	col. 2, line 15.00		4.00
5.00	Cost of Drugs	73.00	0.349548	0	0	col. 2, line 16.00		5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

Provider CCN: 14-0213 | HHA CCN: 14-7452 | Period: From 10/01/2016 To 09/30/2017 | Worksheet H-4 Part I-II | Date/Time Prepared: 2/26/2018 3:14 pm

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	2,659,967	11.00
12.00	Total PPS Reimbursement - Full Episodes with Outliers	0	213,601	12.00
13.00	Total PPS Reimbursement - LUPA Episodes	0	43,720	13.00
14.00	Total PPS Reimbursement - PEP Episodes	0	90,743	14.00
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers	0	41,768	15.00
16.00	Total PPS Outlier Reimbursement - PEP Episodes	0	20,527	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	3,070,326	22.00
23.00	Excess reasonable cost (from line 8)	0	0	23.00
24.00	Subtotal (line 22 minus line 23)	0	3,070,326	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	3,070,326	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	3,070,326	29.00
30.00	OTHER ADJUSTMENT	0	-13,838	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)	0	0	30.50
30.99	Demonstration payment adjustment amount before sequestration	0	0	30.99
31.00	Subtotal (see instructions)	0	3,056,488	31.00
31.01	Sequestration adjustment (see instructions)	0	61,129	31.01
31.02	Demonstration payment adjustment amount after sequestration	0	0	31.02
32.00	Interim payments (see instructions)	0	2,995,359	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 10/01/2016 To 09/30/2017 | Worksheet H-5 | Date/Time Prepared: 2/26/2018 3:14 pm

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		2,995,359	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		2,995,359	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		2,995,359	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 10/01/2016 To 09/30/2017	Worksheet L Parts I-III Date/Time Prepared: 2/26/2018 3:14 pm
	Title XVIII	Hospital	PPS

		1.00	
	PART I - FULLY PROSPECTIVE METHOD		
	CAPITAL FEDERAL AMOUNT		
1.00	Capital DRG other than outlier	4,674,444	1.00
1.01	Model 4 BPCI Capital DRG other than outlier	0	1.01
2.00	Capital DRG outlier payments	198,453	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)	184.50	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)	2.17	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)	15.04	8.00
9.00	Sum of lines 7 and 8	17.21	9.00
10.00	Allowable disproportionate share percentage (see instructions)	3.55	10.00
11.00	Disproportionate share adjustment (see instructions)	165,943	11.00
12.00	Total prospective capital payments (see instructions)	5,038,840	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