

This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). FORM APPROVED OMB NO. 0938-0050

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 140213	Period: From 10/01/2011 To 09/30/2012	Worksheet S Parts I-III Date/Time Prepared: 2/26/2013 7:46 am
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<b>PART I - COST REPORT STATUS</b>			
Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report	Date: 2/26/2013 Time: 7:46 am	
	2. <input type="checkbox"/> Manually submitted cost report		
	3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report		
	4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.		
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by SILVER CROSS HOSPITAL ( 140213 ) for the cost reporting period beginning 10/01/2011 and ending 09/30/2012 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

\_\_\_\_\_  
 Title

\_\_\_\_\_  
 Date

	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
<b>PART III - SETTLEMENT SUMMARY</b>						
1.00	Hospital	0	-604,922	56,566	0	1.00
2.00	Subprovider - IPF	0	65,417	0	0	2.00
3.00	Subprovider - IRF	0	-5,803	0	0	3.00
4.00	SUBPROVIDER I	0	0	0	0	4.00
5.00	Swing bed - SNF	0	0	0	0	5.00
6.00	Swing bed - NF	0	0	0	0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0	0	7.00
8.00	NURSING FACILITY	0	0	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	0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0	0	0	0	11.00
12.00	CMHC I	0	0	0	0	12.00
200.00	Total	0	-545,308	56,566	0	200.00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

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CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

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Encryption Information  
 ECR: Date: 2/26/2013 Time: 7:46 am  
 s9qk1nAa086mZeb3073nr4BoExRfO  
 RaF0K0nM5RX4V0IwEI r59. TWybnq7u  
 3pv812Acva0C9ose  
 PI: Date: 2/26/2013 Time: 7:46 am  
 zu1R3xbmaR3Bma6k3CmaUaTma1Lj 41  
 I1W0n0j XI 9XJ6nA8DFAsrVU1hPJvsC  
 UkyPvZUht50nS04h

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

	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
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1.00	Hospital	0	-604,922	56,566	0	0 1.00
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4.00	SUBPROVIDER I	0	0	0	0	0 4.00
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7.00	SKILLED NURSING FACILITY	0	0	0	0	0 7.00
8.00	NURSING FACILITY	0	0	0	0	0 8.00
9.00	HOME HEALTH AGENCY I	0	0	0	0	0 9.00
10.00	RURAL HEALTH CLINIC I	0	0	0	0	0 10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0	0	0	0	0 11.00
12.00	CMHC I	0	0	0	0	0 12.00
200.00	Total	0	-545,308	56,566	0	0 200.00

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140213		Period: From 10/01/2011 To 09/30/2012		Worksheet S-2 Part I Date/Time Prepared: 2/26/2013 7:45 am					
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 1900 SILVER CROSS BLVD.		PO Box:						1.00		
2.00	City: NEW LENOX		State: IL		Zip Code: 60451		County: WILL		2.00		
		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00		
Hospital and Hospital-Based Component Identification:											
3.00	Hospital		SILVER CROSS HOSPITAL	140213	16974	1	07/01/1966	N	P	P	3.00
4.00	Subprovider - I PF		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		SCH RENAL CT - MORRIS	143526	16974		05/05/2000				18.00
18.01			SCH RENAL - WEST	143516	16974		10/08/1991				18.01
18.02			SCH - RDF	142324	16974		01/01/2004				18.02
19.00	Other										19.00
						From:		To:			
						1.00		2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)					10/01/2011		09/30/2012		20.00	
21.00	Type of Control (see instructions)							1		21.00	
Inpatient PPS Information											
22.00	Does this facility qualify for and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y		N		22.00	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					1		N		23.00	
			In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days			
			1.00	2.00	3.00	4.00	5.00	6.00			
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.		6,033	2,586	0	3	165	0		24.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.		20	56	0	0	0	0		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	

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		Beginning: 1.00	Ending: 2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0				37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.					38.00
		Y/N 1.00	Y/N 2.00			
39.00	Does the facility potentially qualify for the inpatient hospital adjustment for low volume hospitals as deemed by CMS according to the Federal Register? Enter in column 1 "Y" for yes or "N" for no. Additionally, does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)? Enter in column 2 "Y" for yes or "N" for no.					39.00
		V 1.00	XVIII 2.00	XIX 3.00		
<b>Prospective Payment System (PPS)-Capital</b>						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	Y	N		45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N		46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N		47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N		48.00
<b>Teaching Hospitals</b>						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	N				56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.					57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.	N				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N				59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	Y				60.00
		Y/N 1.00	IME Average 2.00	Direct GME Average 3.00		
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)	N	0.00	0.00		61.00
<b>ACA Provisions Affecting the Health Resources and Services Administration (HRSA)</b>						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00				62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00				62.01
<b>Teaching Hospitals that Claim Residents in Non-Provider Settings</b>						
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)	N				63.00
		Unweighted FTEs Nonprovider Site 1.00	Unweighted FTEs in Hospital 2.00	Ratio (col. 1/ (col. 1 + col. 2)) 3.00		
<b>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.</b>						
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 non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000		64.00

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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))	
			1.00	2.00	3.00	
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name. 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 non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000	66.00

	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))	
			1.00	2.00	3.00	
67.00	If line 63 is yes, then, for each primary care residency program in which you are training residents, enter in column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations that occurred in nonprovider settings for each applicable program. Enter in column 4 the number of unweighted primary care FTE residents in your hospital for each applicable program. Enter in column 5 the ratio of column 3 divided by the sum of columns 3 and 4. Use subscripted lines 67.01 through 67.50 for each additional primary care program. If you operated a primary care program that did not have FTE residents in a nonprovider setting, enter zero in column 3 and complete all other columns for each applicable program.		0.00	0.00	0.000000	67.00

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		1.00	2.00	3.00		
<b>Inpatient Psychiatric Facility PPS</b>						
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.	Y				70.00
71.00	If line 70 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)	N		0		71.00
<b>Inpatient Rehabilitation Facility PPS</b>						
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.	Y				75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the subsequent academic years of the new teaching program in existence, enter 5. (see instructions)	N		0		76.00
				1.00		
<b>Long Term Care Hospital PPS</b>						
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N		80.00
<b>TEFRA Providers</b>						
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N		85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.					86.00
				V	XIX	
				1.00	2.00	
<b>Title V and XIX Services</b>						
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N		Y		90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N		N		91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N		92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N		N		93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N		N		94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.		0.00		0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N		96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.		0.00		0.00	97.00
<b>Rural Providers</b>						
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	N				105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N				106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N				107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N				108.00
				Physical	Occupational	Speech
				1.00	2.00	3.00
						Respiratory
						4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00
				1.00	2.00	3.00
<b>Miscellaneous Cost Reporting Information</b>						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.	N			0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N				117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	0				118.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140213	Period: From 10/01/2011 To 09/30/2012	Worksheet S-2 Part I Date/Time Prepared: 2/26/2013 7:45 am	
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	0	0		0
				1.00	2.00
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N		118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.		N	N	120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.		Y		121.00
<b>Transplant Center Information</b>					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00
<b>All Providers</b>					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)		Y		140.00
		1.00	2.00	3.00	
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.					
141.00	Name:	Contractor's Name:		Contractor's Number:	
142.00	Street:	PO Box:			
143.00	City:	State:		Zip Code:	
				1.00	
144.00	Are provider based physicians' costs included in Worksheet A?		Y		144.00
145.00	If costs for renal services are claimed on Worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.		N		145.00
				1.00	2.00
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.		N		146.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.		N		147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.		N		148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.		N		149.00
		Part A	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
156.00	Subprovider - IPF	N	N	N	N
157.00	Subprovider - IRF	N	N	N	N
158.00	SUBPROVIDER				
159.00	SNF	N	N	N	N
160.00	HOME HEALTH AGENCY	N	N	N	N
161.00	CMHC		N	N	N
161.10	CORF		N	N	N

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140213			Period: From 10/01/2011 To 09/30/2012		Worksheet S-2 Part I Date/Time Prepared: 2/26/2013 7:45 am	
							1.00	
<b>Multi campus</b>								
165.00	Is this hospital part of a Multi campus hospital that has one or more campuses in different CBSAs? Enter "Y" for yes or "N" for no.						N	165.00
		<b>Name</b>	<b>County</b>	<b>State</b>	<b>Zip Code</b>	<b>CBSA</b>	<b>FTE/Campus</b>	
		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						0.00	166.00
							1.00	
<b>Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act</b>								
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.						N	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)							168.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 140213	Period: From 10/01/2011 To 09/30/2012	Worksheet S-2 Part II Date/Time Prepared: 2/26/2013 7:45 am	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.		N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)		Y		3.00
			Y/N	Type	Date
			1.00	2.00	3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.		Y	A	4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.		N		5.00
			Y/N	Legal Oper.	
			1.00	2.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?		N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.		Y		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.		N		8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.		N		9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.		N		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.		N		11.00
			Y/N		
			1.00		
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			Y	15.00
		Part A			
		Description	Y/N	Date	
		0	1.00	2.00	
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		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		Y	01/24/2013	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		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		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		N		20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 140213	Period: From 10/01/2011 To 09/30/2012	Worksheet S-2 Part II Date/Time Prepared: 2/26/2013 7:45 am
		Part A		
Description		Y/N	Date	
0		1.00	2.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		21.00
				1.00
<b>COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)</b>				
<b>Capital Related Cost</b>				
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions	N		22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.	N		23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions	N		24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.	N		25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.	N		26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.	N		27.00
<b>Interest Expense</b>				
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.	N		28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions	N		29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.	N		30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.	N		31.00
<b>Purchased Services</b>				
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.	N		32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.			33.00
<b>Provider-Based Physicians</b>				
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.	Y		34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.	N		35.00
		Y/N	Date	
		1.00	2.00	
<b>Home Office Costs</b>				
36.00	Were home office costs claimed on the cost report?	Y		36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.	N		37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.	N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.	N		39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.	N		40.00
		1.00	2.00	
<b>Cost Report Preparer Contact Information</b>				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	JOHN	KREPPS	41.00
42.00	Enter the employer/company name of the cost report preparer.	SILVER CROSS HOSPITAL		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	815-300-7084	JKREPPS@SILVERCROSS.ORG	43.00

		Part B		
		Y/N	Date	
		3.00	4.00	
<b>PS&amp;R Data</b>				
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	01/24/2013	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		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		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		21.00
		3.00		
<b>Cost Report Preparer Contact Information</b>				
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	VICE PRESIDENT OF FINANCE		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 140213

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet S-3  
Part I  
Date/Time Prepared:  
2/26/2013 7:45 am

Cost Center Description	Worksheet A	No. of Beds	Bed Days	CAH Hours	
	Line Number	2.00	3.00	4.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	223	85,466	0.00	1.00
2.00 HMO					2.00
3.00 HMO IPF Subprovider					3.00
4.00 HMO IRF Subprovider					4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					5.00
6.00 Hospital Adults & Peds. Swing Bed NF					6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		223	85,466	0.00	7.00
8.00 INTENSIVE CARE UNIT	31.00	22	7,460	0.00	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				13.00
14.00 Total (see instructions)		245	92,926	0.00	14.00
15.00 CAH visits					15.00
16.00 SUBPROVIDER - IPF	40.00	20	7,320		16.00
17.00 SUBPROVIDER - IRF	41.00	24	7,748		17.00
18.00 SUBPROVIDER	42.00	0	0		18.00
19.00 SKILLED NURSING FACILITY	44.00	0	0		19.00
20.00 NURSING FACILITY	45.00	0	0		20.00
21.00 OTHER LONG TERM CARE					21.00
22.00 HOME HEALTH AGENCY	101.00				22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)					23.00
24.00 HOSPICE					24.00
25.00 CMHC - CMHC	99.00				25.00
25.10 CMHC - CORF	99.10				25.10
26.00 RURAL HEALTH CLINIC	88.00				26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				26.25
27.00 Total (sum of lines 14-26)		289			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
33.00 LTCH non-covered days					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 140213

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet S-3  
Part I  
Date/Time Prepared:  
2/26/2013 7:45 am

Cost Center Description	I/P Days / O/P Visits / Trips					
	Title V	Title XVIII	Title XIX	Total All Patients		
	5.00	6.00	7.00	8.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	0	26,003	7,070	48,464		1.00
2.00 HMO		927	165			2.00
3.00 HMO IPF Subprovider		0	0			3.00
4.00 HMO IRF Subprovider		0	0			4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0	0		5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0	0	0	0		6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	0	26,003	7,070	48,464		7.00
8.00 INTENSIVE CARE UNIT	0	2,591	647	4,336		8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	0		742	4,970		13.00
14.00 Total (see instructions)	0	28,594	8,459	57,770		14.00
15.00 CAH visits	0	0	0	0		15.00
16.00 SUBPROVIDER - IPF	0	1,268	545	3,601		16.00
17.00 SUBPROVIDER - IRF	0	3,973	76	5,388		17.00
18.00 SUBPROVIDER	0	0	0	0		18.00
19.00 SKILLED NURSING FACILITY	0	0	0	0		19.00
20.00 NURSING FACILITY	0		0	0		20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0	16,111	0	20,618		22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
25.00 CMHC - CMHC	0	0	0	0		25.00
25.10 CMHC - CORF	0	0	0	0		25.10
26.00 RURAL HEALTH CLINIC	0	0	0	0		26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0		26.25
27.00 Total (sum of lines 14-26)						27.00
28.00 Observation Bed Days	0		641	5,708		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)			162	1,087		32.00
33.00 LTCH non-covered days		0				33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 140213

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet S-3  
Part I  
Date/Time Prepared:  
2/26/2013 7:45 am

Cost Center Description	Full Time Equivalents			Discharges		
	Total Interns & Residents	Employees On Payroll	Nonpaid Workers	Title V	Title XVIII	
	9.00	10.00	11.00	12.00	13.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)				0	6,575	1.00
2.00 HMO					0	2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	1,391.29	0.00	0	6,575	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	19.24	0.00	0	172	16.00
17.00 SUBPROVIDER - IRF	0.00	33.59	0.00	0	320	17.00
18.00 SUBPROVIDER	0.00	0.00	0.00	0	0	18.00
19.00 SKILLED NURSING FACILITY	0.00	0.00	0.00			19.00
20.00 NURSING FACILITY	0.00	0.00	0.00			20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0.00	20.38	0.00			22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
25.00 CMHC - CMHC	0.00	0.00	0.00			25.00
25.10 CMHC - CORF	0.00	0.00	0.00			25.10
26.00 RURAL HEALTH CLINIC	0.00	0.00	0.00			26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00	0.00	0.00			26.25
27.00 Total (sum of lines 14-26)	0.00	1,464.50	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
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 140213

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet S-3  
Part I  
Date/Time Prepared:  
2/26/2013 7:45 am

Cost Center Description	Discharges			
	Title XIX	Total All Patients		
	14.00	15.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	2,996	16,619		1.00
2.00 HMO				2.00
3.00 HMO IPF Subprovider				3.00
4.00 HMO IRF Subprovider				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF				5.00
6.00 Hospital Adults & Peds. Swing Bed NF				6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)				7.00
8.00 INTENSIVE CARE UNIT				8.00
9.00 CORONARY CARE UNIT				9.00
10.00 BURN INTENSIVE CARE UNIT				10.00
11.00 SURGICAL INTENSIVE CARE UNIT				11.00
12.00 OTHER SPECIAL CARE (SPECIFY)				12.00
13.00 NURSERY				13.00
14.00 Total (see instructions)	2,996	16,619		14.00
15.00 CAH visits				15.00
16.00 SUBPROVIDER - IPF	99	581		16.00
17.00 SUBPROVIDER - IRF	6	426		17.00
18.00 SUBPROVIDER	0	0		18.00
19.00 SKILLED NURSING FACILITY				19.00
20.00 NURSING FACILITY				20.00
21.00 OTHER LONG TERM CARE				21.00
22.00 HOME HEALTH AGENCY				22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)				23.00
24.00 HOSPICE				24.00
25.00 CMHC - CMHC				25.00
25.10 CMHC - CORF				25.10
26.00 RURAL HEALTH CLINIC				26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER				26.25
27.00 Total (sum of lines 14-26)				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
33.00 LTCH non-covered days				33.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140213

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet S-3  
Part II  
Date/Time Prepared:  
2/26/2013 7:45 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
<b>PART II - WAGE DATA</b>							
<b>SALARIES</b>							
1.00	Total salaries (see instructions)	200.00	88,677,259	0	88,677,259	3,046,162.00	29.11
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00
5.00	Physician-Part B		0	0	0	0.00	0.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	0	0	0.00	0.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		5,326,889	-279,270	5,047,619	163,120.00	30.94
<b>OTHER WAGES &amp; RELATED COSTS</b>							
11.00	Contract labor (see instructions)		1,510,670	0	1,510,670	34,550.00	43.72
12.00	Contract management and administrative services		0	0	0	0.00	0.00
13.00	Contract Labor: Physician-Part A - Administrative		192,340	0	192,340	1,549.00	124.17
14.00	Home office salaries & wage-related costs		7,682,969	0	7,682,969	20,744.00	370.37
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
<b>WAGE-RELATED COSTS</b>							
17.00	Wage-related costs (core) Wkst S-3, Part IV line 24		26,939,501	0	26,939,501		
18.00	Wage-related costs (other) Wkst S-3, Part IV line 25		0	0	0		
19.00	Excluded areas		1,625,982	0	1,625,982		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FOHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
<b>OVERHEAD COSTS - DIRECT SALARIES</b>							
26.00	Employee Benefits	4.00	460,419	0	460,419	13,247.00	34.76
27.00	Administrative & General	5.00	11,719,865	-405,696	11,314,169	396,062.00	28.57
28.00	Administrative & General under contract (see inst.)		144,058	0	144,058	3,125.00	46.10
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00
30.00	Operation of Plant	7.00	2,710,844	0	2,710,844	112,178.00	24.17
31.00	Laundry & Linen Service	8.00	74,222	0	74,222	5,342.00	13.89
32.00	Housekeeping	9.00	1,862,836	0	1,862,836	133,289.00	13.98
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00
34.00	Dietary	10.00	1,568,333	-844,304	724,029	54,338.00	13.32
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00
36.00	Cafeteria	11.00	0	844,304	844,304	54,338.00	15.54
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00
38.00	Nursing Administration	13.00	1,473,220	0	1,473,220	44,671.00	32.98
39.00	Central Services and Supply	14.00	1,075,246	-572,237	503,009	32,246.00	15.60
40.00	Pharmacy	15.00	2,260,264	0	2,260,264	55,195.00	40.95
41.00	Medical Records & Medical Records Library	16.00	1,774,973	0	1,774,973	81,142.00	21.87

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140213

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet S-3  
Part II  
Date/Time Prepared:  
2/26/2013 7:45 am

		Worksheet A Line Number	Amount Reported	Recl assi fi cati on 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	
42.00	Soci al Servi ce	17.00	0	405,696	405,696	12,667.00	32.03	42.00
43.00	Other General Servi ce	18.00	0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140213

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet S-3  
Part III  
Date/Time Prepared:  
2/26/2013 7:45 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cation of Sal aries (from Worksheet A-6)	Adjusted Sal aries (col . 2 ± col . 3)	Paid Hours Related to Sal aries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
<b>PART III - HOSPITAL WAGE INDEX SUMMARY</b>							
1.00	Net salaries (see instructions)	88,821,317	0	88,821,317	3,049,287.00	29.13	1.00
2.00	Excluded area salaries (see instructions)	5,326,889	-279,270	5,047,619	163,120.00	30.94	2.00
3.00	Subtotal salaries (line 1 minus line 2)	83,494,428	279,270	83,773,698	2,886,167.00	29.03	3.00
4.00	Subtotal other wages & related costs (see inst.)	9,385,979	0	9,385,979	56,843.00	165.12	4.00
5.00	Subtotal wage-related costs (see inst.)	26,939,501	0	26,939,501	0.00	32.16	5.00
6.00	Total (sum of lines 3 thru 5)	119,819,908	279,270	120,099,178	2,943,010.00	40.81	6.00
7.00	Total overhead cost (see instructions)	25,124,280	-572,237	24,552,043	997,840.00	24.61	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 140213	Period: From 10/01/2011 To 09/30/2012	Worksheet S-3 Part IV Date/Time Prepared: 2/26/2013 7:45 am
				Amount Reported
				1.00
<b>PART IV - WAGE RELATED COSTS</b>				
<b>Part A - Core List</b>				
<b>RETIREMENT COST</b>				
1.00	401K Employer Contributions			0 1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution			0 2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)		3,799,049	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)		0	4.00
<b>PLAN ADMINISTRATIVE COSTS (Paid to External Organization)</b>				
5.00	401K/TSA Plan Administration Fees		0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan		0	6.00
7.00	Employee Managed Care Program Administration Fees		0	7.00
<b>HEALTH AND INSURANCE COST</b>				
8.00	Health Insurance (Purchased or Self Funded)		14,637,880	8.00
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		550,789	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		95,975	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)		637,895	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		1,956,524	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		0	16.00
<b>TAXES</b>				
17.00	FICA-Employers Portion Only		6,607,058	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		115,000	19.00
20.00	State or Federal Unemployment Taxes		0	20.00
<b>OTHER</b>				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))		0	21.00
22.00	Day Care Cost and Allowances		0	22.00
23.00	Tuition Reimbursement		165,315	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		28,565,485	24.00
<b>Part B - Other than Core Related Cost</b>				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 140213	Period: From 10/01/2011 To 09/30/2012	Worksheet S-3 Part V Date/Time Prepared: 2/26/2013 7:45 am
Cost Center Description			Contract Labor	Benefit Cost
			1.00	2.00
<b>PART V - Contract Labor and Benefit Cost</b>				
<b>Hospital and Hospital-Based Component Identification:</b>				
1.00	Total facility's contract labor and benefit cost		0	0 1.00
2.00	Hospital		0	0 2.00
3.00	Subprovider - IPF		0	0 3.00
4.00	Subprovider - IRF		0	0 4.00
5.00	Subprovider - (Other)		0	0 5.00
6.00	Swing Beds - SNF		0	0 6.00
7.00	Swing Beds - NF		0	0 7.00
8.00	Hospital-Based SNF		0	0 8.00
9.00	Hospital-Based NF		0	0 9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA		0	0 11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC		0	0 14.00
15.00	Hospital-Based Health Clinic FQHC		0	0 15.00
16.00	Hospital-Based-CMHC		0	0 16.00
16.10	Hospital-Based-CMHC 10		0	0 16.10
17.00	Renal Dialysis		0	0 17.00
18.00	Other		0	0 18.00

HOME HEALTH AGENCY STATISTICAL DATA		Provider CCN: 140213 Component CCN: 147452		Period: From 10/01/2011 To 09/30/2012		Worksheet S-4 Date/Time Prepared: 2/26/2013 7:45 am	
				Home Health Agency I		PPS	
				1.00			
0.00	County			WILL		0.00	
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
HOME HEALTH AGENCY STATISTICAL DATA							
1.00	Home Health Aide Hours	0	2,976	0	0	2,976	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	921.00	22.00	337.00	1,280.00	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		6.75	0.00	6.75	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			12.27	0.00	12.27	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			0.00	73.54	73.54	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			0.00	1.68	1.68	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.00	3.96	3.96	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.06	5.27	5.33	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			1.42	0.00	1.42	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		LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		Without Outliers	With Outliers	3.00	4.00	5.00	
		1.00	2.00	3.00	4.00	5.00	
PPS ACTIVITY DATA							
21.00	Skilled Nursing Visits	7,186	322	152	509	8,169	21.00
22.00	Skilled Nursing Visit Charges	1,642,995	73,418	34,821	116,593	1,867,827	22.00
23.00	Physical Therapy Visits	4,622	39	21	274	4,956	23.00
24.00	Physical Therapy Visit Charges	991,788	8,264	4,516	58,842	1,063,410	24.00
25.00	Occupational Therapy Visits	1,309	12	7	81	1,409	25.00
26.00	Occupational Therapy Visit Charges	280,814	2,529	1,505	17,419	302,267	26.00
27.00	Speech Pathology Visits	79	0	0	9	88	27.00
28.00	Speech Pathology Visit Charges	17,995	0	0	2,054	20,049	28.00
29.00	Medical Social Service Visits	181	8	0	7	196	29.00
30.00	Medical Social Service Visit Charges	56,664	2,468	0	2,183	61,315	30.00
31.00	Home Health Aide Visits	1,259	37	0	178	1,474	31.00
32.00	Home Health Aide Visit Charges	175,708	5,107	0	24,902	205,717	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	14,636	418	180	1,058	16,292	33.00
34.00	Other Charges	17,549	1,999	134	1,353	21,035	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	3,183,513	93,785	40,976	223,346	3,541,620	35.00
36.00	Total Number of Episodes (standard/non outlier)	773		64	58	895	36.00
37.00	Total Number of Outlier Episodes		9		5	14	37.00
38.00	Total Non-Routine Medical Supply Charges	11,043	301	1,204	1,040	13,588	38.00

HOSPITAL RENAL DIALYSIS DEPARTMENT STATISTICAL DATA

Provider CCN: 140213

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet S-5

Date/Time Prepared:  
2/26/2013 7:45 am

		Outpatient		Training			
		Regular	High Flux	Hemodialysis	CAPD / CCPD		
		1.00	2.00	3.00	4.00		
1.00	Number of patients in program at end of cost reporting period	0	0	0	0		1.00
2.00	Number of times per week patient receives dialysis	3.00	0.00	0.00	0.00		2.00
3.00	Average patient dialysis time including setup	4.50	0.00	0.00	0.00		3.00
4.00	CAPD exchanges per day				0.00		4.00
5.00	Number of days in year dialysis furnished	233	0				5.00
6.00	Number of stations	52	0	0	0		6.00
7.00	Treatment capacity per day per station	8	0				7.00
8.00	Utilization (see instructions)	0.00	0.00				8.00
9.00	Average times dialyzers re-used	0.00	0.00				9.00
10.00	Percentage of patients re-using dialyzers	0.00	0.00				10.00
<b>TRANSPLANT INFORMATION</b>							
11.00	Number of patients on transplant list	0					11.00
12.00	Number of patients transplanted during the cost reporting period	0					12.00
<b>EPOETIN</b>							
13.00	Net costs of Epoetin furnished to all maintenance dialysis patients by the provider.	0					13.00
14.00	Epoetin amount from Worksheet A for Home Dialysis program	0					14.00
15.00	Number of EPO units furnished relating to the renal dialysis department	0					15.00
16.00	Number of EPO units furnished relating to the home dialysis department	0					16.00
<b>ARANESP</b>							
17.00	Net costs of ARANESP furnished to all maintenance dialysis patients by the provider.	0					17.00
18.00	ARANESP amount from Worksheet A for Home Dialysis program	0					18.00
19.00	Number of ARANESP units furnished relating to the renal dialysis department	0					19.00
20.00	Number of ARANESP units furnished relating to the home dialysis department	0					20.00
						MCP	INITIAL METHOD
						1.00	2.00
<b>PHYSICIAN PAYMENT METHOD</b>							
21.00	enter "X" if method(s) is applicable				X		21.00

		Home		
		Hemodialysis	CAPD / CCPD	
		5.00	6.00	
1.00	Number of patients in program at end of cost reporting period	0	0	1.00
2.00	Number of times per week patient receives dialysis	0.00	0.00	2.00
3.00	Average patient dialysis time including setup			3.00
4.00	CAPD exchanges per day		0.00	4.00
5.00	Number of days in year dialysis furnished			5.00
6.00	Number of stations			6.00
7.00	Treatment capacity per day per station			7.00
8.00	Utilization (see instructions)			8.00
9.00	Average times dialyzers re-used			9.00
10.00	Percentage of patients re-using dialyzers			10.00
<b>TRANSPLANT INFORMATION</b>				
11.00	Number of patients on transplant list			11.00
12.00	Number of patients transplanted during the cost reporting period			12.00
<b>EPOETIN</b>				
13.00	Net costs of Epoetin furnished to all maintenance dialysis patients by the provider.			13.00
14.00	Epoetin amount from Worksheet A for Home Dialysis program			14.00
15.00	Number of EPO units furnished relating to the renal dialysis department			15.00
16.00	Number of EPO units furnished relating to the home dialysis department			16.00
<b>ARANESP</b>				
17.00	Net costs of ARANESP furnished to all maintenance dialysis patients by the provider.			17.00
18.00	ARANESP amount from Worksheet A for Home Dialysis program			18.00
19.00	Number of ARANESP units furnished relating to the renal dialysis department			19.00
20.00	Number of ARANESP units furnished relating to the home dialysis department			20.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 140213	Period: From 10/01/2011 To 09/30/2012	Worksheet S-10 Date/Time Prepared: 2/26/2013 7:45 am
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			1.00		
<b>Uncompensated and indigent care cost computation</b>					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.292230	1.00	
<b>Medicaid (see instructions for each line)</b>					
2.00	Net revenue from Medicaid		26,849,557	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00	
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		Y	4.00	
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		0	5.00	
6.00	Medicaid charges		88,952,323	6.00	
7.00	Medicaid cost (line 1 times line 6)		25,994,537	7.00	
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		0	8.00	
<b>State Children's Health Insurance Program (SCHIP) (see instructions for each line)</b>					
9.00	Net revenue from stand-alone SCHIP		0	9.00	
10.00	Stand-alone SCHIP charges		0	10.00	
11.00	Stand-alone SCHIP cost (line 1 times line 10)		0	11.00	
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00	
<b>Other state or local government indigent care program (see instructions for each line)</b>					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00	
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00	
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00	
<b>Uncompensated care (see instructions for each line)</b>					
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00	
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		0	19.00	
			1.00		
			2.00		
			3.00		
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	32,988,000	0	32,988,000	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	9,640,083	0	9,640,083	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	9,640,083	0	9,640,083	23.00
			1.00		
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00	
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit		0	25.00	
26.00	Total bad debt expense for the entire hospital complex (see instructions)		11,882,140	26.00	
27.00	Medicare bad debts for the entire hospital complex (see instructions)		1,043,914	27.00	
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)		10,838,226	28.00	
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)		3,167,255	29.00	
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)		12,807,338	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		12,807,338	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140213

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet A  
Date/Time Prepared:  
2/26/2013 7:45 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)			
		1.00	2.00	3.00	4.00	5.00			
<b>GENERAL SERVICE COST CENTERS</b>									
1.00	00100	CAP REL COSTS-BLDG & FIXT		51,851,960		51,851,960	-22,180,081	29,671,879	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0		0	10,143,886	10,143,886	2.00
4.00	00400	EMPLOYEE BENEFITS	460,419	28,960,001	29,420,420	0	0	29,420,420	4.00
5.00	00500	ADMINI STRATIVE & GENERAL	11,719,865	39,095,087	50,814,952	9,775,496	0	60,590,448	5.00
7.00	00700	OPERATION OF PLANT	2,710,844	5,981,516	8,692,360	0	0	8,692,360	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	74,222	374,737	448,959	0	0	448,959	8.00
9.00	00900	HOUSEKEEPING	1,862,836	1,363,656	3,226,492	0	0	3,226,492	9.00
10.00	01000	DIETARY	1,568,333	1,596,853	3,165,186	-1,703,962	0	1,461,224	10.00
11.00	01100	CAFETERIA	0	0	0	1,703,962	0	1,703,962	11.00
13.00	01300	NURSING ADMINISTRATION	1,473,220	25,283	1,498,503	0	0	1,498,503	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,075,246	1,064,570	2,139,816	-1,533,173	0	606,643	14.00
15.00	01500	PHARMACY	2,260,264	9,870,474	12,130,738	-8,203,538	0	3,927,200	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,774,973	197,671	1,972,644	0	0	1,972,644	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	405,696	0	405,696	17.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	316,356	378,087	694,443	-1,737	0	692,706	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>									
30.00	03000	ADULTS & PEDIATRICS	15,906,340	2,316,306	18,222,646	2,763,680	0	20,986,326	30.00
31.00	03100	INTENSIVE CARE UNIT	3,432,797	590,179	4,022,976	-198,239	0	3,824,737	31.00
40.00	04000	SUBPROVIDER - I PF	1,295,316	164,436	1,459,752	-305,036	0	1,154,716	40.00
41.00	04100	SUBPROVIDER - I RF	2,198,554	516,681	2,715,235	86,538	0	2,801,773	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	0	42.00
43.00	04300	NURSERY	5,162,989	378,279	5,541,268	-4,281,466	0	1,259,802	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>									
50.00	05000	OPERATING ROOM	6,034,702	21,760,975	27,795,677	-16,472,147	0	11,323,530	50.00
51.00	05100	RECOVERY ROOM	1,065,499	66,089	1,131,588	-8,174	0	1,123,414	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	539,222	539,222	1,953,506	0	2,492,728	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,732,361	8,530,241	14,262,602	-5,464,935	0	8,797,667	54.00
54.01	05401	ULTRASOUND	958,778	103,461	1,062,239	-4,108	0	1,058,131	54.01
57.00	05700	CT SCAN	910,612	653,618	1,564,230	-26,793	0	1,537,437	57.00
58.00	05800	MRI	494,752	477,842	972,594	-69	0	972,525	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	0	59.00
60.00	06000	LABORATORY	3,213,223	3,775,001	6,988,224	87,845	0	7,076,069	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	122,132	1,555,273	1,677,405	0	0	1,677,405	63.00
65.00	06500	RESPIRATORY THERAPY	1,162,361	301,629	1,463,990	23,466	0	1,487,456	65.00
65.01	06501	SLEEP LAB	90,956	88,946	179,902	-78	0	179,824	65.01
66.00	06600	PHYSICAL THERAPY	1,271,962	474,833	1,746,795	-6,039	0	1,740,756	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,179,158	204,681	1,383,839	-4,449	0	1,379,390	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	910,983	205,818	1,116,801	299,879	0	1,416,680	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	162,371	16,470	178,841	12,359	0	191,200	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	10,265,827	0	10,265,827	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	14,179,450	0	14,179,450	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	8,172,365	0	8,172,365	73.00
74.00	07400	RENAL DIALYSIS	2,995,228	2,767,527	5,762,755	40,733	0	5,803,488	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>									
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	0	89.00
90.00	09000	CLINIC	309,488	226,684	536,172	-4,944	0	531,228	90.00
90.01	09001	HOMER GLEN LAB	269,723	163,342	433,065	-277	0	432,788	90.01
90.02	09002	HOMER GLEN FEC	809,266	674,016	1,483,282	-14,052	0	1,469,230	90.02
90.03	09003	WOMEN'S HEALTH	595,391	471,976	1,067,367	-29,547	0	1,037,820	90.03
91.00	09100	EMERGENCY	5,059,946	798,400	5,858,346	276,382	0	6,134,728	91.00
91.01	09101	OP MENTAL HEALTH	231,379	6,672	238,051	314,722	0	552,773	91.01
91.02	09102	DIABETES CENTER	287,751	22,404	310,155	-85,776	0	224,379	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>									
94.00	09400	HOME PROGRAM DIALYSIS	78,774	268,275	347,049	-52	0	346,997	94.00
99.00	09900	CMHC	0	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	1,426,805	871,767	2,298,572	22,880	0	2,321,452	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>									
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	88,666,175	189,750,938	278,417,113	0	0	278,417,113	118.00
<b>NONREIMBURSABLE COST CENTERS</b>									
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	11,084	79	11,163	0	0	11,163	190.00



RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140213

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet A  
Date/Time Prepared:  
2/26/2013 7:45 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
<b>GENERAL SERVICE COST CENTERS</b>					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-9,355,067	20,316,812	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	10,143,886	2.00
4.00	00400	EMPLOYEE BENEFITS	-37,034	29,383,386	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-16,755,950	43,834,498	5.00
7.00	00700	OPERATION OF PLANT	3,028	8,695,388	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	448,959	8.00
9.00	00900	HOUSEKEEPING	-831	3,225,661	9.00
10.00	01000	DIETARY	-1,386,637	74,587	10.00
11.00	01100	CAFETERIA	0	1,703,962	11.00
13.00	01300	NURSING ADMINISTRATION	-243	1,498,260	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-7,032	599,611	14.00
15.00	01500	PHARMACY	-32	3,927,168	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-24,259	1,948,385	16.00
17.00	01700	SOCIAL SERVICE	0	405,696	17.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	-88,658	604,048	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS	-820,828	20,165,498	30.00
31.00	03100	INTENSIVE CARE UNIT	-8,450	3,816,287	31.00
40.00	04000	SUBPROVIDER - I PF	-9,996	1,144,720	40.00
41.00	04100	SUBPROVIDER - I RF	-100,035	2,701,738	41.00
42.00	04200	SUBPROVIDER	0	0	42.00
43.00	04300	NURSERY	-2,411	1,257,391	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	-8,428	11,315,102	50.00
51.00	05100	RECOVERY ROOM	0	1,123,414	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	2,492,728	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-282,843	8,514,824	54.00
54.01	05401	ULTRASOUND	0	1,058,131	54.01
57.00	05700	CT SCAN	0	1,537,437	57.00
58.00	05800	MRI	0	972,525	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	-11,248	7,064,821	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	1,677,405	63.00
65.00	06500	RESPIRATORY THERAPY	-9,080	1,478,376	65.00
65.01	06501	SLEEP LAB	-82,500	97,324	65.01
66.00	06600	PHYSICAL THERAPY	-17	1,740,739	66.00
67.00	06700	OCCUPATIONAL THERAPY	-10	1,379,380	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	-355,820	1,060,860	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	-18,664	172,536	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	10,265,827	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	14,179,450	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	8,172,365	73.00
74.00	07400	RENAL DIALYSIS	-47,320	5,756,168	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	0	531,228	90.00
90.01	09001	HOMER GLEN LAB	0	432,788	90.01
90.02	09002	HOMER GLEN FEC	-362,314	1,106,916	90.02
90.03	09003	WOMEN'S HEALTH	-17,253	1,020,567	90.03
91.00	09100	EMERGENCY	-327,062	5,807,666	91.00
91.01	09101	OP MENTAL HEALTH	-155,552	397,221	91.01
91.02	09102	DIABETES CENTER	-613	223,766	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
94.00	09400	HOME PROGRAM DIALYSIS	0	346,997	94.00
99.00	09900	CMHC	0	0	99.00
99.10	09910	CORF	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	-8,087	2,313,365	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
109.00	10900	PANCREAS ACQUISITION	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-30,281,246	248,135,867	118.00
<b>NONREIMBURSABLE COST CENTERS</b>					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	11,163	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
200.00		TOTAL (SUM OF LINES 118-199)	-30,281,246	248,147,030	200.00

RECLASSIFICATIONS

Provider CCN: 140213

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet A-6  
Date/Time Prepared:  
2/26/2013 7:45 am

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
<b>A - STERILE PROCESSING</b>					
1.00	ADULTS & PEDIATRICS	30.00	8,010	11,135	1.00
2.00	OPERATING ROOM	50.00	512,725	712,672	2.00
3.00	DELIVERY ROOM & LABOR ROOM	52.00	36,051	50,110	3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	4,006	5,568	4.00
5.00	CLINIC	90.00	2,289	3,182	5.00
6.00	EMERGENCY	91.00	9,156	12,726	6.00
	TOTALS		572,237	795,393	
<b>B - OP MHU</b>					
1.00	OP MENTAL HEALTH	91.01	279,270	35,452	1.00
	TOTALS		279,270	35,452	
<b>C - CAPITAL INSURANCE</b>					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	176,018	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	195,731	2.00
	TOTALS		0	371,749	
<b>D - CHARGEABLE DRUGS</b>					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	8,172,365	1.00
	TOTALS		0	8,172,365	
<b>E - MALPRACTICE INSURANCE</b>					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	11,840,464	1.00
	TOTALS		0	11,840,464	
<b>F - DEPRECIATION</b>					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	9,967,868	1.00
	TOTALS		0	9,967,868	
<b>G - PHYSICIAN FEES</b>					
1.00	ADULTS & PEDIATRICS	30.00	0	784,044	1.00
2.00	INTENSIVE CARE UNIT	31.00	0	21,996	2.00
3.00	SUBPROVIDER - IPF	40.00	0	9,996	3.00
4.00	SUBPROVIDER - IRF	41.00	0	99,996	4.00
5.00	OPERATING ROOM	50.00	0	10,836	5.00
6.00	LABORATORY	60.00	0	89,004	6.00
7.00	RESPIRATORY THERAPY	65.00	0	28,332	7.00
8.00	ELECTROCARDIOLOGY	69.00	0	300,009	8.00
9.00	ELECTROENCEPHALOGRAPHY	70.00	0	18,664	9.00
10.00	RENAL DIALYSIS	74.00	0	84,584	10.00
11.00	EMERGENCY	91.00	0	367,546	11.00
12.00	DIABETES CENTER	91.02	0	5,004	12.00
13.00	HOME HEALTH AGENCY	101.00	0	34,992	13.00
	TOTALS		0	1,855,003	
<b>H - LABOR AND DELIVERY</b>					
1.00	ADULTS & PEDIATRICS	30.00	2,139,569	0	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	2,131,411	0	2.00
	TOTALS		4,270,980	0	
<b>I - SOCIAL SERVICES</b>					
1.00	SOCIAL SERVICE	17.00	405,696	0	1.00
	TOTALS		405,696	0	
<b>K - CHARGEABLE SUPPLIES</b>					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	10,265,827	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00

RECLASSIFICATIONS

Provider CCN: 140213

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet A-6

Date/Time Prepared:  
2/26/2013 7:45 am

		Increases			
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
27.00		0.00	0	0	27.00
28.00		0.00	0	0	28.00
29.00		0.00	0	0	29.00
30.00		0.00	0	0	30.00
	TOTALS		0	10,265,827	
L - DIABETES MANAGEMENT					
1.00	ADULTS & PEDIATRICS	30.00	88,304	2,476	1.00
	TOTALS		88,304	2,476	
M - DIETARY RECLASS					
1.00	CAFETERIA	11.00	844,304	859,658	1.00
	TOTALS		844,304	859,658	
N - IMPLANTABLE DEVICES					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	14,179,450	1.00
2.00		0.00	0	0	2.00
	TOTALS		0	14,179,450	
500.00	Grand Total: Increases		6,460,791	58,345,705	500.00

RECLASSIFICATIONS

Provider CCN: 140213

Period: From 10/01/2011 To 09/30/2012

Worksheet A-6  
Date/Time Prepared: 2/26/2013 7:45 am

Decreases						
Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
6.00	7.00	8.00	9.00	10.00		
<b>A - STERILE PROCESSING</b>						
1.00	CENTRAL SERVICES & SUPPLY	14.00	572,237	795,393	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
	TOTALS		572,237	795,393		
<b>B - OP MHU</b>						
1.00	SUBPROVIDER - IPF	40.00	279,270	35,452	0	1.00
	TOTALS		279,270	35,452		
<b>C - CAPITAL INSURANCE</b>						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	371,749	9	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		0	371,749		
<b>D - CHARGEABLE DRUGS</b>						
1.00	PHARMACY	15.00	0	8,172,365	0	1.00
	TOTALS		0	8,172,365		
<b>E - MALPRACTICE INSURANCE</b>						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	11,840,464	9	1.00
	TOTALS		0	11,840,464		
<b>F - DEPRECIATION</b>						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	9,967,868	9	1.00
	TOTALS		0	9,967,868		
<b>G - PHYSICIAN FEES</b>						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1,855,003	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
	TOTALS		0	1,855,003		
<b>H - LABOR AND DELIVERY</b>						
1.00	NURSERY	43.00	4,270,980	0	0	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		4,270,980	0		
<b>I - SOCIAL SERVICES</b>						
1.00	ADMINISTRATIVE & GENERAL	5.00	405,696	0	0	1.00
	TOTALS		405,696	0		
<b>K - CHARGEABLE SUPPLIES</b>						
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	165,543	0	1.00
2.00	PHARMACY	15.00	0	31,173	0	2.00
3.00	PARAMED ED PRGM-(SPECIFY)	23.00	0	1,737	0	3.00
4.00	ADULTS & PEDIATRICS	30.00	0	269,858	0	4.00
5.00	INTENSIVE CARE UNIT	31.00	0	220,235	0	5.00
6.00	SUBPROVIDER - IPF	40.00	0	310	0	6.00
7.00	SUBPROVIDER - IRF	41.00	0	13,458	0	7.00
8.00	NURSERY	43.00	0	10,486	0	8.00
9.00	OPERATING ROOM	50.00	0	6,486,072	0	9.00
10.00	RECOVERY ROOM	51.00	0	8,174	0	10.00
11.00	DELIVERY ROOM & LABOR ROOM	52.00	0	264,066	0	11.00
12.00	RADIOLOGY-DIAGNOSTIC	54.00	0	2,517,367	0	12.00
13.00	ULTRASOUND	54.01	0	4,108	0	13.00
14.00	CT SCAN	57.00	0	26,793	0	14.00
15.00	MRI	58.00	0	69	0	15.00
16.00	LABORATORY	60.00	0	1,159	0	16.00
17.00	WOMEN'S HEALTH	90.03	0	29,547	0	17.00
18.00	RESPIRATORY THERAPY	65.00	0	4,866	0	18.00
19.00	SLEEP LAB	65.01	0	78	0	19.00
20.00	PHYSICAL THERAPY	66.00	0	6,039	0	20.00
21.00	OCCUPATIONAL THERAPY	67.00	0	4,449	0	21.00
22.00	ELECTROCARDIOLOGY	69.00	0	130	0	22.00
23.00	ELECTROENCEPHALOGRAPHY	70.00	0	6,305	0	23.00
24.00	RENAL DIALYSIS	74.00	0	43,851	0	24.00
25.00	CLINIC	90.00	0	10,415	0	25.00
26.00	EMERGENCY	91.00	0	113,046	0	26.00
27.00	HOMER GLEN LAB	90.01	0	277	0	27.00

RECLASSIFICATIONS

Provider CCN: 140213

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet A-6  
Date/Time Prepared:  
2/26/2013 7:45 am

Decreases							
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
28.00	HOME PROGRAM DIALYSIS	94.00	0	52	0		28.00
29.00	HOME HEALTH AGENCY	101.00	0	12,112	0		29.00
30.00	HOMER GLEN FEC	90.02	0	14,052	0		30.00
	TOTALS		0	10,265,827			
L - DIABETES MANAGEMENT							
1.00	DIABETES CENTER	91.02	88,304	2,476	0		1.00
	TOTALS		88,304	2,476			
M - DIETARY RECLASS							
1.00	DIETARY	10.00	844,304	859,658	0		1.00
	TOTALS		844,304	859,658			
N - IMPLANTABLE DEVICES							
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	2,957,142	0		1.00
2.00	OPERATING ROOM	50.00	0	11,222,308	0		2.00
	TOTALS		0	14,179,450			
500.00	Grand Total: Decreases		6,460,791	58,345,705			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140213

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet A-7  
Parts I-III  
Date/Time Prepared:  
2/26/2013 7:45 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>							
1.00	Land	31,661,000	0	0	0	16,859,839	1.00
2.00	Land Improvements	5,522,000	7,980,094	0	7,980,094	0	2.00
3.00	Buildings and Fixtures	186,599,000	145,299,326	0	145,299,326	0	3.00
4.00	Building Improvements	344,954,000	0	0	0	344,954,000	4.00
5.00	Fixed Equipment	0	12,459,337	0	12,459,337	0	5.00
6.00	Movable Equipment	111,845,000	53,112,532	0	53,112,532	0	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	680,581,000	218,851,289	0	218,851,289	361,813,839	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	680,581,000	218,851,289	0	218,851,289	361,813,839	10.00
<b>SUMMARY OF CAPITAL</b>							
Cost Center Description		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
<b>PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2</b>							
1.00	CAP REL COSTS-BLDG & FIXT	22,089,088	0	17,346,057	12,353,386	63,429	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	22,089,088	0	17,346,057	12,353,386	63,429	3.00
<b>COMPUTATION OF RATIOS</b>							
Cost Center Description		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	ALLOCATION OF OTHER CAPITAL Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
<b>PART III - RECONCILIATION OF CAPITAL COSTS CENTERS</b>							
1.00	CAP REL COSTS-BLDG & FIXT	372,660,918	0	372,660,918	0.693170	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	164,957,532	0	164,957,532	0.306830	0	2.00
3.00	Total (sum of lines 1-2)	537,618,450	0	537,618,450	1.000000	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140213

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet A-7  
Parts I-III  
Date/Time Prepared:  
2/26/2013 7:45 am

		Ending Balance	Fully Depreciated Assets			
		6.00	7.00			
<b>PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES</b>						
1.00	Land	14,801,161	0		1.00	
2.00	Land Improvements	13,502,094	0		2.00	
3.00	Buildings and Fixtures	331,898,326	0		3.00	
4.00	Building Improvements	0	0		4.00	
5.00	Fixed Equipment	12,459,337	0		5.00	
6.00	Movable Equipment	164,957,532	0		6.00	
7.00	HIT designated Assets	0	0		7.00	
8.00	Subtotal (sum of lines 1-7)	537,618,450	0		8.00	
9.00	Reconciling Items	0	0		9.00	
10.00	Total (line 8 minus line 9)	537,618,450	0		10.00	
<b>SUMMARY OF CAPITAL</b>						
Cost Center Description		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)			
		14.00	15.00			
<b>PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2</b>						
1.00	CAP REL COSTS-BLDG & FIXT	0	51,851,960		1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		2.00	
3.00	Total (sum of lines 1-2)	0	51,851,960		3.00	
<b>ALLOCATION OF OTHER CAPITAL</b>						
Cost Center Description		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	SUMMARY OF CAPITAL Depreciation	Lease
		6.00	7.00	8.00	9.00	10.00
<b>PART III - RECONCILIATION OF CAPITAL COSTS CENTERS</b>						
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	412,387	0
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	10,143,886	0
3.00	Total (sum of lines 1-2)	0	0	0	10,556,273	0

RECONCILIATION OF CAPITAL COSTS CENTERS	Provider CCN: 140213	Period: From 10/01/2011 To 09/30/2012	Worksheet A-7 Parts I-III Date/Time Prepared: 2/26/2013 7:45 am
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Cost Center Description	SUMMARY OF CAPITAL					Total (2) (sum of cols. 9 through 14)	
	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)			
	11.00	12.00	13.00	14.00	15.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	7,487,610	12,353,386	63,429	0	20,316,812	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	10,143,886	2.00
3.00	Total (sum of lines 1-2)	7,487,610	12,353,386	63,429	0	30,460,698	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 140213

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet A-8  
Date/Time Prepared:  
2/26/2013 7:45 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		
			Cost Center		Line #
			1.00	2.00	3.00
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			OCAP REL COSTS-BLDG & FIXT		1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			OCAP REL COSTS-MVBLE EQUIP		2.00
3.00 Investment income - other (chapter 2)		0			0.00
4.00 Trade, quantity, and time discounts (chapter 8)		0			0.00
5.00 Refunds and rebates of expenses (chapter 8)		0			0.00
6.00 Rental of provider space by suppliers (chapter 8)		0			0.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0			0.00
8.00 Television and radio service (chapter 21)		0			0.00
9.00 Parking lot (chapter 21)		0			0.00
10.00 Provider-based physician adjustment	A-8-2	-4,049,990			
11.00 Sale of scrap, waste, etc. (chapter 23)		0			0.00
12.00 Related organization transactions (chapter 10)	A-8-1	1,366,684			
13.00 Laundry and linen service		0			0.00
14.00 Cafeteria-employees and guests		0			0.00
15.00 Rental of quarters to employee and others		0			0.00
16.00 Sale of medical and surgical supplies to other than patients		0			0.00
17.00 Sale of drugs to other than patients		0			0.00
18.00 Sale of medical records and abstracts		0			0.00
19.00 Nursing school (tuition, fees, books, etc.)		0			0.00
20.00 Vending machines		0			0.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0			0.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0			0.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		ORESPIRATORY THERAPY		65.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		OPHYSICAL THERAPY		66.00
25.00 Utilization review - physicians' compensation (chapter 21)			0*** Cost Center Deleted ***		114.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT			OCAP REL COSTS-BLDG & FIXT		1.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			OCAP REL COSTS-MVBLE EQUIP		2.00
28.00 Non-physician Anesthetist			0*** Cost Center Deleted ***		19.00
29.00 Physicians' assistant			0		0.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		OCCUPATIONAL THERAPY		67.00
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		OSPEECH PATHOLOGY		68.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0			0.00
33.00 OTHER ADJUSTMENTS (SPECIFY) (3)					0.00
33.01 OTHER REV-RESPIRATORY THERAPY	B	-87	RESPIRATORY THERAPY		65.00
33.02 OTHER REV-HOMER FEC	B	-362,314	HOMER GLEN FEC		90.02
33.03 OTHER REV-ANESTHESIOLOGY	B	-32	OPERATING ROOM		50.00
38.00 1996 DSR INTEXP. ADD ON	A	14,351	CAP REL COSTS-BLDG & FIXT		1.00
39.00 OTHER REVENUE-CENTRAL SUPPLY	B	-7,032	CENTRAL SERVICES & SUPPLY		14.00
40.00 TELEPHONE BENEFITS	B	-18,874	EMPLOYEE BENEFITS		4.00
41.00 PHYSICIANS	B	-153,981	ADMINISTRATIVE & GENERAL		5.00
42.00 CONTRIBUTIONS EXPENSE	A	-46,289	ADMINISTRATIVE & GENERAL		5.00
43.00 BAD DEBTS	B	-11,874,095	ADMINISTRATIVE & GENERAL		5.00
44.00 AHA & IHA DUES-POLITICAL LOBBY	A	-33,727	ADMINISTRATIVE & GENERAL		5.00
45.00 OTHER REV-A & G	B	-2,049,756	ADMINISTRATIVE & GENERAL		5.00
45.01 TELEPHONE COSTS	A	-88,967	ADMINISTRATIVE & GENERAL		5.00
45.02 COMMUNITY RELATIONS	A	-1,286,758	ADMINISTRATIVE & GENERAL		5.00
45.04 ADVERTISING ADMIN (EXPENSE ACCT# 510)	A	-3,841	ADMINISTRATIVE & GENERAL		5.00
45.05 OTHER REV-EMPLOYEE BENEFITS	B	-18,160	EMPLOYEE BENEFITS		4.00
45.06 OTHER REV-OPERATION & PLANT	B	3,028	OPERATION OF PLANT		7.00
45.07 OTHER REV-CAFÉ'-EMP & GUESTS	B	-1,379,274	DIETARY		10.00
45.08 OTHER REV-VENDING MACHINES	B	-7,363	DIETARY		10.00
45.09 OTHER REV-NURSING ADMIN	B	-243	NURSING ADMINISTRATION		13.00
45.11 OTHER REV-PARAMED ED PROGRAM	B	-88,658	PARAMED ED PRGM-(SPECIFY)		23.00
45.12 OTHER REV-A & P	B	-232	ADULTS & PEDIATRICS		30.00

Provider CCN: 140213	Period: From 10/01/2011 To 09/30/2012	Worksheet A-8 Date/Time Prepared: 2/26/2013 7:45 am
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Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted		
			Cost Center	Line #	
			1.00	2.00	
45.13 OTHER REV-PSYCH	B	-11,052	OP MENTAL HEALTH	91.01	45.13
45.15 OTHER REV-NURSERY	B	-2,411	NURSERY	43.00	45.15
45.16 OTHER REV-RADIOLOGY	B	-18,749	RADIOLOGY-DIAGNOSTIC	54.00	45.16
45.19 OTHER REV-LAB	B	-850	LABORATORY	60.00	45.19
45.20 OTHER REV-PHYSICAL THERAPY	B	-17	PHYSICAL THERAPY	66.00	45.20
45.22 OTHER REV-OCCUPATIONAL THERAPY	B	-10	OCCUPATIONAL THERAPY	67.00	45.22
45.24 OTHER REV-CARDIAC CATH	B	-37,460	ELECTROCARDIOLOGY	69.00	45.24
45.25 OTHER REV-DIALYSIS	B	-50	RENAL DIALYSIS	74.00	45.25
45.27 OTHER REV-ER	B	-494	EMERGENCY	91.00	45.27
45.32 OTHER REV-DIABETES	B	-550	DIABETES CENTER	91.02	45.32
45.34 HHA BAD DEBTS	B	-8,045	HOME HEALTH AGENCY	101.00	45.34
45.35 INVESTMENT INCOME	B	-9,858,447	CAP REL COSTS-BLDG & FIXT	1.00	45.35
46.00 OTHER REV-MED REC	B	-24,259	MEDICAL RECORDS & LIBRARY	16.00	46.00
46.01 OTHER REV-OPER ROOM	B	-60	OPERATING ROOM	50.00	46.01
46.03 OTHER REV-HHA	B	-42	HOME HEALTH AGENCY	101.00	46.03
46.05 OTHER REV-ENVIRONMENTAL SERVICES	B	-831	HOUSEKEEPING	9.00	46.05
46.06 ADMINISTRATIVE MISC. EXPENSE	A	-214,985	ADMINISTRATIVE & GENERAL	5.00	46.06
46.07 OTHER REV-PHARMACY	B	-32	PHARMACY	15.00	46.07
46.08 OTHER REV-REHAB	B	-39	SUBPROVIDER - IRF	41.00	46.08
46.14 OTHER REV-WOMEN'S HEALTH	B	-17,253	WOMEN'S HEALTH	90.03	46.14
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-30,281,246			50.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 140213

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet A-8

Date/Time Prepared:  
2/26/2013 7:45 am

Cost Center Description		Wkst. A-7 Ref.	
		5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	0	2.00
3.00	Investment income - other (chapter 2)	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	0	7.00
8.00	Television and radio service (chapter 21)	0	8.00
9.00	Parking lot (chapter 21)	0	9.00
10.00	Provider-based physician adjustment	0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	0	11.00
12.00	Related organization transactions (chapter 10)	0	12.00
13.00	Laundry and linen service	0	13.00
14.00	Cafeteria-employees and guests	0	14.00
15.00	Rental of quarters to employee and others	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	0	16.00
17.00	Sale of drugs to other than patients	0	17.00
18.00	Sale of medical records and abstracts	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)	0	19.00
20.00	Vending machines	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	0	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	0	27.00
28.00	Non-physician Anesthetist		28.00
29.00	Physicians' assistant	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)		30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	0	32.00
33.00	OTHER ADJUSTMENTS (SPECIFY) (3)	0	33.00
33.01	OTHER REV-RESPIRATORY THERAPY	0	33.01
33.02	OTHER REV-HOMER FEC	0	33.02
33.03	OTHER REV-ANETHESIOLOGY	0	33.03
38.00	1996 DSR INTEXP. ADD ON	9	38.00
39.00	OTHER REVENUE-CENTRAL SUPPLY	0	39.00
40.00	TELEPHONE BENEFITS	0	40.00
41.00	PHYSICIANS	0	41.00
42.00	CONTRIBUTIONS EXPENSE	0	42.00
43.00	BAD DEBTS	0	43.00
44.00	AHA & IHA DUES-POLITICAL LOBBY	0	44.00
45.00	OTHER REV A & G	0	45.00
45.01	TELEPHONE COSTS	0	45.01
45.02	COMMUNITY RELATIONS	0	45.02
45.04	ADVERTISING ADMIN (EXPENSE ACCT# 510)	0	45.04
45.05	OTHER REV-EMPLOYEE BENEFITS	0	45.05
45.06	OTHER REV-OPERATION & PLANT	0	45.06
45.07	OTHER REV-CAFÉ'-EMP & GUESTS	0	45.07
45.08	OTHER REV-VENDING MACHINES	0	45.08
45.09	OTHER REV-NURSING ADMIN	0	45.09
45.11	OTHER REV-PARAMED ED PROGRAM	0	45.11
45.12	OTHER REV-A & P	0	45.12
45.13	OTHER REV-PSYCH	0	45.13
45.15	OTHER REV-NURSERY	0	45.15
45.16	OTHER REV-RADIOLOGY	0	45.16
45.19	OTHER REV-LAB	0	45.19
45.20	OTHER REV-PHYSICAL THERAPY	0	45.20
45.22	OTHER REV-OCCUPATIONAL THERAPY	0	45.22

ADJUSTMENTS TO EXPENSES

Provider CCN: 140213

Period:  
From 10/01/2011  
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Worksheet A-8

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Cost Center Description		Wkst. A-7 Ref.	
		5.00	
45.24	OTHER REV-CARDIAC CATH	0	45.24
45.25	OTHER REV-DIALYSIS	0	45.25
45.27	OTHER REV-ER	0	45.27
45.32	OTHER REV-DIABETES	0	45.32
45.34	HHA BAD DEBTS	0	45.34
45.35	INVESTMENT INCOME	11	45.35
46.00	OTHER REV-MED REC	0	46.00
46.01	OTHER REV-OPER ROOM	0	46.01
46.03	OTHER REV-HHA	0	46.03
46.05	OTHER REV-ENVIRONMENTAL SERVICES	0	46.05
46.06	ADMINISTRATIVE MISCELL. EXPENSE	0	46.06
46.07	OTHER REV-PHARMACY	0	46.07
46.08	OTHER REV-REHAB	0	46.08
46.14	OTHER REV-WOMEN'S HEALTH	0	46.14
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		50.00

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

Provider CCN: 140213

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet A-8-1

Date/Time Prepared:  
2/26/2013 7:45 am

	Line No.	Cost Center	Expense Items	
	1.00	2.00	3.00	
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>				
1.00		5.00 ADMINISTRATIVE & GENERAL	MANAGEMENT FEE	1.00
2.00		1.00 CAP REL COSTS-BLDG & FIXT	DEPRECIATION	2.00
3.00		54.00 RADIOLOGY-DIAGNOSTIC	LEASE	3.00
4.00		69.00 ELECTROCARDIOLOGY	LEASE	4.00
4.01		5.00 ADMINISTRATIVE & GENERAL	LEASE	4.01
4.02		30.00 ADULTS & PEDIATRICS	LEASE	4.02
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			5.00

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

	Symbol (1)	Name	Percentage of Ownership	
	1.00	2.00	3.00	
<b>B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:</b>				

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

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

6.00		G	SILVER CROSS H0	100.00	6.00
7.00				0.00	7.00
8.00				0.00	8.00
9.00				0.00	9.00
10.00				0.00	10.00
100.00	G. Other (financial or non-financial) specify:		SILVER CROSS H0		100.00

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

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

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

Provider CCN: 140213

Period: From 10/01/2011 To 09/30/2012

Worksheet A-8-1

Date/Time Prepared: 2/26/2013 7:45 am

	Amount of Allowable Cost	Amount Included in Wks. A, column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
<b>A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:</b>						
1.00	8,663,775	7,448,960	1,214,815	0		1.00
2.00	489,029	0	489,029	9		2.00
3.00	0	264,094	-264,094	0		3.00
4.00	0	18,355	-18,355	0		4.00
4.01	0	18,160	-18,160	0		4.01
4.02	0	36,551	-36,551	0		4.02
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.	9,152,804	7,786,120	1,366,684		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			
Name	Percentage of Ownership	Type of Business	
4.00	5.00	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	SILVER CROSS HO	100.00	HOME OFFICE	6.00
7.00		0.00		7.00
8.00		0.00		8.00
9.00		0.00		9.00
10.00		0.00		10.00
100.00	G. Other (financial or non-financial) specify:			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 140213

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet A-8-2

Date/Time Prepared:  
2/26/2013 7:45 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
	1.00	2.00	3.00	4.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	2,200,206	2,200,206	1.00
2.00	30.00	ADULTS & PEDIATRICS	784,045	784,045	2.00
3.00	31.00	INTENSIVE CARE UNIT	21,996	0	3.00
4.00	40.00	SUBPROVIDER - IPF	9,996	9,996	4.00
5.00	41.00	SUBPROVIDER - IRF	99,996	99,996	5.00
6.00	50.00	OPERATING ROOM	10,836	5,832	6.00
7.00	65.00	RESPIRATORY THERAPY	28,332	0	7.00
8.00	66.00	PHYSICAL THERAPY	0	0	8.00
9.00	69.00	ELECTROCARDIOLOGY	300,005	300,005	9.00
10.00	70.00	ELECTROENCEPHALOGRAPHY	18,664	18,664	10.00
11.00	74.00	RENAL DIALYSIS	84,584	0	11.00
12.00	90.00	CLINIC	0	0	12.00
13.00	91.00	EMERGENCY	367,546	302,550	13.00
14.00	60.00	LABORATORY	89,004	0	14.00
15.00	91.02	DIABETES CENTER	5,004	0	15.00
16.00	65.01	SLEEP LAB	82,500	82,500	16.00
17.00	91.01	OP MENTAL HEALTH	144,500	144,500	17.00
200.00			4,247,214	3,948,294	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 140213

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet A-8-2

Date/Time Prepared:  
2/26/2013 7:45 am

	Provider Component	RCE Amount	Physician/Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	5.00	6.00	7.00	8.00	9.00	
1.00	0	0	0	0	0	1.00
2.00	0	0	0	0	0	2.00
3.00	21,996	177,200	159	13,546	677	3.00
4.00	0	154,100	13	963	48	4.00
5.00	0	154,100	0	0	0	5.00
6.00	5,004	208,000	25	2,500	125	6.00
7.00	28,332	177,200	227	19,339	967	7.00
8.00	0	177,200	0	0	0	8.00
9.00	0	177,200	0	0	0	9.00
10.00	0	177,200	0	0	0	10.00
11.00	84,584	177,200	438	37,314	1,866	11.00
12.00	0	177,200	0	0	0	12.00
13.00	64,996	177,200	481	40,978	2,049	13.00
14.00	89,004	215,700	758	78,606	3,930	14.00
15.00	5,004	177,200	58	4,941	247	15.00
16.00	0	0	0	0	0	16.00
17.00	0	0	0	0	0	17.00
200.00	298,920		2,159	198,187	9,909	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 140213

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet A-8-2

Date/Time Prepared:  
2/26/2013 7:45 am

	Cost of Memberships & Continuing Education 12.00	Provider Component Share of col. 12 13.00	Physician Cost of Malpractice Insurance 14.00	Provider Component Share of col. 14 15.00	Adjusted RCE Limit 16.00	
1.00	0	0	0	0	0	1.00
2.00	0	0	0	0	0	2.00
3.00	0	0	0	0	13,546	3.00
4.00	0	0	0	0	963	4.00
5.00	0	0	0	0	0	5.00
6.00	0	0	0	0	2,500	6.00
7.00	0	0	0	0	19,339	7.00
8.00	0	0	0	0	0	8.00
9.00	0	0	0	0	0	9.00
10.00	0	0	0	0	0	10.00
11.00	0	0	0	0	37,314	11.00
12.00	0	0	0	0	0	12.00
13.00	0	0	0	0	40,978	13.00
14.00	0	0	0	0	78,606	14.00
15.00	0	0	0	0	4,941	15.00
16.00	0	0	0	0	0	16.00
17.00	0	0	0	0	0	17.00
200.00	0	0	0	0	198,187	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 140213

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet A-8-2

Date/Time Prepared:  
2/26/2013 7:45 am

	RCE	Adjustment	
	Disallowance		
	17.00	18.00	
1.00	0	2,200,206	1.00
2.00	0	784,045	2.00
3.00	8,450	8,450	3.00
4.00	0	9,996	4.00
5.00	0	99,996	5.00
6.00	2,504	8,336	6.00
7.00	8,993	8,993	7.00
8.00	0	0	8.00
9.00	0	300,005	9.00
10.00	0	18,664	10.00
11.00	47,270	47,270	11.00
12.00	0	0	12.00
13.00	24,018	326,568	13.00
14.00	10,398	10,398	14.00
15.00	63	63	15.00
16.00	0	82,500	16.00
17.00	0	144,500	17.00
200.00	101,696	4,049,990	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140213

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet B  
Part I  
Date/Time Prepared:  
2/26/2013 7:45 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst Allocation 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	20,316,812	20,316,812			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	10,143,886		10,143,886		2.00
4.00 00400	EMPLOYEE BENEFITS	29,383,386	84,830	4,088	29,472,304	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	43,834,498	4,232,833	4,187,098	3,779,939	5.00
7.00 00700	OPERATION OF PLANT	8,695,388	254,923	163,093	905,663	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	448,959	97,399	0	24,797	8.00
9.00 00900	HOUSEKEEPING	3,225,661	190,263	29,681	622,353	9.00
10.00 01000	DIETARY	74,587	752,890	21,542	241,890	10.00
11.00 01100	CAFETERIA	1,703,962	184,216	25,120	282,073	11.00
13.00 01300	NURSING ADMINISTRATION	1,498,260	94,333	46,954	492,187	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	599,611	667,326	129,215	168,050	14.00
15.00 01500	PHARMACY	3,927,168	245,852	0	755,129	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	1,948,385	144,177	9,010	592,999	16.00
17.00 01700	SOCIAL SERVICE	405,696	0	0	135,539	17.00
23.00 02300	PARAMED PRGM-(SPECIFY)	604,048	40,903	30,829	105,691	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	20,165,498	4,254,431	348,653	6,061,147	30.00
31.00 03100	INTENSIVE CARE UNIT	3,816,287	654,800	120,635	1,146,860	31.00
40.00 04000	SUBPROVIDER - I/PF	1,144,720	399,359	16,098	339,450	40.00
41.00 04100	SUBPROVIDER - I/RF	2,701,738	682,011	20,385	734,513	41.00
42.00 04200	SUBPROVIDER	0	0	0	0	42.00
43.00 04300	NURSERY	1,257,391	1,197,256	92,582	298,010	43.00
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
45.00 04500	NURSING FACILITY	0	0	0	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	11,315,102	1,888,165	1,180,397	2,187,423	50.00
51.00 05100	RECOVERY ROOM	1,123,414	149,187	30,420	355,971	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	2,492,728	226,934	181,520	724,125	52.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	8,514,824	1,049,667	1,710,940	1,916,457	54.00
54.01 05401	ULTRASOUND	1,058,131	174,585	100,168	320,317	54.01
57.00 05700	CT SCAN	1,537,437	67,856	379,753	304,225	57.00
58.00 05800	MRI	972,525	87,465	132,116	165,291	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00 06000	LABORATORY	7,064,821	191,084	29,881	1,073,502	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	60.01
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	1,677,405	7,213	4,358	40,803	63.00
65.00 06500	RESPIRATORY THERAPY	1,478,376	60,729	46,633	388,332	65.00
65.01 06501	SLEEP LAB	97,324	0	13,162	30,387	65.01
66.00 06600	PHYSICAL THERAPY	1,740,739	90,661	32,558	424,949	66.00
67.00 06700	OCCUPATIONAL THERAPY	1,379,380	44,661	2,003	393,944	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00 06900	ELECTROCARDIOLOGY	1,060,860	54,682	73,047	304,349	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	172,536	56,194	53	54,246	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	10,265,827	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	14,179,450	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	8,172,365	0	313,632	0	73.00
74.00 07400	RENAL DIALYSIS	5,756,168	188,493	58,831	1,000,673	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00 09000	CLINIC	531,228	26,909	1,419	104,161	90.00
90.01 09001	HOMER GLEN LAB	432,788	112,862	2,104	90,111	90.01
90.02 09002	HOMER GLEN FEC	1,106,916	0	32,902	270,367	90.02
90.03 09003	WOMEN'S HEALTH	1,020,567	0	256,322	198,914	90.03
91.00 09100	EMERGENCY	5,807,666	1,314,610	311,933	1,693,531	91.00
91.01 09101	OP MENTAL HEALTH	397,221	152,772	2,315	170,602	91.01
91.02 09102	DIABETES CENTER	223,766	22,417	1,222	66,633	91.02
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
94.00 09400	HOME PROGRAM DIALYSIS	346,997	0	0	26,318	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	2,313,365	0	1,214	476,680	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
109.00 10900	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00 11000	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00 11100	ISLET ACQUISITION	0	0	0	0	111.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140213

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet B  
Part I  
Date/Time Prepared:  
2/26/2013 7:45 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal		
		BLDG & FIXT	MVBLE EQUIP				
	0	1.00	2.00	4.00	4A		
118.00	SUBTOTALS (SUM OF LINES 1-117)	248,135,867	20,144,948	10,143,886	29,468,601	247,960,300	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	11,163	144,134	0	3,703	159,000	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	27,730	0	0	27,730	192.00
200.00	Cross Foot Adjustments					0	200.00
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	248,147,030	20,316,812	10,143,886	29,472,304	248,147,030	202.00

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 140213	Period: From 10/01/2011 To 09/30/2012	Worksheet B Part I Date/Time Prepared: 2/26/2013 7:45 am		
Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY
			5.00	7.00	8.00	9.00	10.00
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	56,034,368				5.00
7.00	00700	OPERATION OF PLANT	2,922,311	12,941,378			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	166,592	80,060	817,807		8.00
9.00	00900	HOUSEKEEPING	1,186,522	156,392	0	5,410,872	9.00
10.00	01000	DIETARY	318,191	618,858	6,953	263,564	2,298,475
11.00	01100	CAFETERIA	640,335	151,422	0	64,489	0
13.00	01300	NURSING ADMINISTRATION	621,774	77,539	0	33,023	0
14.00	01400	CENTRAL SERVICES & SUPPLY	456,239	548,526	4,434	233,610	0
15.00	01500	PHARMACY	1,437,418	202,085	0	86,065	0
16.00	01600	MEDICAL RECORDS & LIBRARY	785,939	118,510	0	50,472	0
17.00	01700	SOCIAL SERVICE	157,865	0	0	0	0
23.00	02300	PARAMED ED PRGM-(SPECIFY)	227,936	33,622	27,194	14,319	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	8,992,167	3,497,040	380,425	1,489,346	1,655,241
31.00	03100	INTENSIVE CARE UNIT	1,673,801	538,230	37,716	229,226	311,018
40.00	04000	SUBPROVIDER - I PF	554,074	328,263	2,713	139,803	123,975
41.00	04100	SUBPROVIDER - I RF	1,207,140	560,597	30,844	238,751	208,241
42.00	04200	SUBPROVIDER	0	0	0	0	0
43.00	04300	NURSERY	829,885	984,116	7,222	419,123	0
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0
45.00	04500	NURSING FACILITY	0	0	0	0	0
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	4,833,372	1,552,027	107,489	660,989	0
51.00	05100	RECOVERY ROOM	483,886	122,628	8,350	52,226	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,057,411	186,534	32,411	79,443	0
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,847,744	862,801	44,334	367,456	0
54.01	05401	ULTRASOUND	482,197	143,504	8,302	61,117	0
57.00	05700	CT SCAN	667,723	55,776	0	23,754	0
58.00	05800	MRI	395,919	71,894	1,345	30,619	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	2,438,195	157,067	519	66,893	0
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	504,533	5,929	0	2,525	0
65.00	06500	RESPIRATORY THERAPY	575,787	49,918	0	21,259	0
65.01	06501	SLEEP LAB	41,089	0	0	0	0
66.00	06600	PHYSICAL THERAPY	667,617	74,521	0	31,738	0
67.00	06700	OCCUPATIONAL THERAPY	530,845	36,710	17,667	15,635	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	435,453	44,947	408	19,142	0
70.00	07000	ELECTROENCEPHALOGRAPHY	82,552	46,190	233	19,672	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	2,994,285	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,135,791	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	2,475,153	0	0	0	0
74.00	07400	RENAL DIALYSIS	2,042,940	154,936	9,115	65,986	0
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00	09000	CLINIC	193,590	22,119	0	9,420	0
90.01	09001	HOMER GLEN LAB	186,049	92,770	0	39,510	0
90.02	09002	HOMER GLEN FEC	411,316	0	0	0	0
90.03	09003	WOMEN'S HEALTH	430,455	0	0	0	0
91.00	09100	EMERGENCY	2,662,334	1,080,578	90,133	460,205	0
91.01	09101	OP MENTAL HEALTH	210,855	125,575	0	53,481	0
91.02	09102	DIABETES CENTER	91,597	18,426	0	7,847	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
<b>OTHER REIMBURSABLE COST CENTERS</b>							
94.00	09400	HOME PROGRAM DIALYSIS	108,887	0	0	0	0
99.00	09900	CMHC	0	0	0	0	0
99.10	09910	CORF	0	0	0	0	0
101.00	10100	HOME HEALTH AGENCY	814,140	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0
111.00	11100	ISLET ACQUISITION	0	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	55,979,904	12,800,110	817,807	5,350,708	2,298,475
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	46,376	118,475	0	50,457	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	8,088	22,793	0	9,707	0
200.00		Cross Foot Adjustments					200.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 140213			Period: From 10/01/2011 To 09/30/2012		Worksheet B Part I Date/Time Prepared: 2/26/2013 7:45 am	
Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY		
		5.00	7.00	8.00	9.00	10.00		
201.00	Negative Cost Centers	0	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	56,034,368	12,941,378	817,807	5,410,872	2,298,475	202.00	

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140213

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet B  
Part I  
Date/Time Prepared:  
2/26/2013 7:45 am

Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	3,051,617					11.00
13.00	01300		2,922,717				13.00
14.00	01400	42,320	0	2,849,331			14.00
15.00	01500	72,463	0	21,631	6,747,811		15.00
16.00	01600	106,510	0	2,157	0	3,758,159	16.00
17.00	01700	16,628	0	0	0	0	17.00
23.00	02300	71,343	0	22,922	23,651	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	801,755	1,788,019	173,687	11,604	1,487,288	30.00
31.00	03100	118,605	264,524	39,857	3,518	457,806	31.00
40.00	04000	52,531	0	2,576	668	119,474	40.00
41.00	04100	91,711	204,505	10,448	0	116,190	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	32,982	73,529	18,989	470	160,618	43.00
44.00	04400	0	0	0	0	0	44.00
45.00	04500	0	0	0	0	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	266,861	0	246,251	50,501	0	50.00
51.00	05100	31,917	0	6,415	29	0	51.00
52.00	05200	81,200	181,103	25,227	943	0	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	251,243	0	90,165	14,321	0	54.00
54.01	05401	34,020	0	7,271	84	0	54.01
57.00	05700	33,938	0	22,575	129	0	57.00
58.00	05800	15,153	0	4,954	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	169,962	0	353,629	0	0	60.00
60.01	06001	0	0	0	0	0	60.01
63.00	06300	5,297	0	18,922	0	0	63.00
65.00	06500	54,033	0	28,036	0	0	65.00
65.01	06501	4,915	0	3,365	0	0	65.01
66.00	06600	51,221	0	3,381	118	345,962	66.00
67.00	06700	47,753	0	3,327	172	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	38,224	0	4,447	44	0	69.00
70.00	07000	7,754	0	589	0	80,357	70.00
71.00	07100	0	0	1,479,840	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	5,594,023	0	73.00
74.00	07400	113,718	253,593	106,230	1,019,499	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	10,184	0	3,685	0	15,164	90.00
90.01	09001	12,696	0	21,445	0	0	90.01
90.02	09002	29,405	0	9,663	5,834	0	90.02
90.03	09003	24,737	0	6,734	135	0	90.03
91.00	09100	216,787	0	72,228	8,377	975,300	91.00
91.01	09101	12,887	0	820	0	0	91.01
91.02	09102	14,962	33,345	849	0	0	91.02
92.00	09200	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
94.00	09400	0	0	31,309	13,342	0	94.00
99.00	09900	0	0	0	0	0	99.00
99.10	09910	0	0	0	0	0	99.10
101.00	10100	55,644	124,099	5,707	349	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	10900	0	0	0	0	0	109.00
110.00	11000	0	0	0	0	0	110.00
111.00	11100	0	0	0	0	0	111.00
118.00		3,050,006	2,922,717	2,849,331	6,747,811	3,758,159	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	1,611	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140213

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet B  
Part I  
Date/Time Prepared:  
2/26/2013 7:45 am

Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	3,051,617	2,922,717	2,849,331	6,747,811	3,758,159	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140213

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet B  
Part I  
Date/Time Prepared:  
2/26/2013 7:45 am

Cost Center Description			SOCIAL SERVICE	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	23.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS						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	715,728					17.00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	1,202,458				23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	621,687	0	51,727,988	0	51,727,988	30.00
31.00	03100	INTENSIVE CARE UNIT	38,125	49,310	9,500,318	0	9,500,318	31.00
40.00	04000	SUBPROVIDER - I/PF	0	0	3,223,704	0	3,223,704	40.00
41.00	04100	SUBPROVIDER - I/RF	0	0	6,807,074	0	6,807,074	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	5,372,173	0	5,372,173	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	24,288,577	0	24,288,577	50.00
51.00	05100	RECOVERY ROOM	0	0	2,364,443	0	2,364,443	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	5,269,579	0	5,269,579	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	18,669,952	0	18,669,952	54.00
54.01	05401	ULTRASOUND	0	0	2,389,696	0	2,389,696	54.01
57.00	05700	CT SCAN	0	0	3,093,166	0	3,093,166	57.00
58.00	05800	MRI	0	0	1,877,281	0	1,877,281	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	25,727	11,571,280	0	11,571,280	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	2,266,985	0	2,266,985	63.00
65.00	06500	RESPIRATORY THERAPY	0	66,461	2,769,564	0	2,769,564	65.00
65.01	06501	SLEEP LAB	0	0	190,242	0	190,242	65.01
66.00	06600	PHYSICAL THERAPY	0	0	3,463,465	0	3,463,465	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	2,472,097	0	2,472,097	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	23,583	2,059,186	0	2,059,186	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	520,376	0	520,376	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	14,739,952	0	14,739,952	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	18,315,241	0	18,315,241	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	16,555,173	0	16,555,173	73.00
74.00	07400	RENAL DIALYSIS	0	0	10,770,182	0	10,770,182	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	8,896	0	926,775	0	926,775	90.00
90.01	09001	HOMER GLEN LAB	0	0	990,335	0	990,335	90.01
90.02	09002	HOMER GLEN FEC	0	0	1,866,403	0	1,866,403	90.02
90.03	09003	WOMEN'S HEALTH	0	0	1,937,864	0	1,937,864	90.03
91.00	09100	EMERGENCY	47,020	975,740	15,716,442	0	15,716,442	91.00
91.01	09101	OP MENTAL HEALTH	0	0	1,126,528	0	1,126,528	91.01
91.02	09102	DIABETES CENTER	0	0	481,064	0	481,064	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	526,853	0	526,853	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	61,637	3,852,835	0	3,852,835	101.00
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	715,728	1,202,458	247,702,793	0	247,702,793	118.00

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 140213		Period: From 10/01/2011 To 09/30/2012		Worksheet B Part I Date/Time Prepared: 2/26/2013 7:45 am	
Cost Center Description			SOCIAL SERVICE	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	23.00	24.00	25.00	26.00	
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	375,919	0	375,919	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	68,318	0	68,318	192.00
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	715,728	1,202,458	248,147,030	0	248,147,030	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140213

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet B  
Part II  
Date/Time Prepared:  
2/26/2013 7:45 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	
		BLDG & FIXT	MVBLE EQUIP			
		1.00	2.00			
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS	0	84,830	4,088	88,918	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	4,232,833	4,187,098	8,419,931	5.00
7.00 00700	OPERATION OF PLANT	0	254,923	163,093	418,016	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	94,399	0	97,399	8.00
9.00 00900	HOUSEKEEPING	0	190,263	29,681	219,944	9.00
10.00 01000	DIETARY	0	752,890	21,542	774,432	10.00
11.00 01100	CAFETERIA	0	184,216	25,120	209,336	11.00
13.00 01300	NURSING ADMINISTRATION	0	94,333	46,954	141,287	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	667,326	129,215	796,541	14.00
15.00 01500	PHARMACY	0	245,852	0	245,852	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	144,177	9,010	153,187	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	17.00
23.00 02300	PARAMED PRGM-(SPECIFY)	0	40,903	30,829	71,732	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	0	4,254,431	348,653	4,603,084	30.00
31.00 03100	INTENSIVE CARE UNIT	0	654,800	120,635	775,435	31.00
40.00 04000	SUBPROVIDER - IPF	0	399,359	16,098	415,457	40.00
41.00 04100	SUBPROVIDER - IRF	0	682,011	20,385	702,396	41.00
42.00 04200	SUBPROVIDER	0	0	0	0	42.00
43.00 04300	NURSERY	0	1,197,256	92,582	1,289,838	43.00
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
45.00 04500	NURSING FACILITY	0	0	0	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	0	1,888,165	1,180,397	3,068,562	50.00
51.00 05100	RECOVERY ROOM	0	149,187	30,420	179,607	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	226,934	181,520	408,454	52.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	1,049,667	1,710,940	2,760,607	54.00
54.01 05401	ULTRASOUND	0	174,585	100,168	274,753	54.01
57.00 05700	CT SCAN	0	67,856	379,753	447,609	57.00
58.00 05800	MRI	0	87,465	132,116	219,581	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00 06000	LABORATORY	0	191,084	29,881	220,965	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	60.01
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	7,213	4,358	11,571	63.00
65.00 06500	RESPIRATORY THERAPY	0	60,729	46,633	107,362	65.00
65.01 06501	SLEEP LAB	0	0	13,162	13,162	65.01
66.00 06600	PHYSICAL THERAPY	0	90,661	32,558	123,219	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	44,661	2,003	46,664	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00 06900	ELECTROCARDIOLOGY	0	54,682	73,047	127,729	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	0	56,194	53	56,247	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	313,632	313,632	73.00
74.00 07400	RENAL DIALYSIS	0	188,493	58,831	247,324	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00 09000	CLINIC	0	26,909	1,419	28,328	90.00
90.01 09001	HOMER GLEN LAB	0	112,862	2,104	114,966	90.01
90.02 09002	HOMER GLEN FEC	0	0	32,902	32,902	90.02
90.03 09003	WOMEN'S HEALTH	0	0	256,322	256,322	90.03
91.00 09100	EMERGENCY	0	1,314,610	311,933	1,626,543	91.00
91.01 09101	OP MENTAL HEALTH	0	152,772	2,315	155,087	91.01
91.02 09102	DIABETES CENTER	0	22,417	1,222	23,639	91.02
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
94.00 09400	HOME PROGRAM DIALYSIS	0	0	0	0	94.00
99.00 09900	CMHC	0	0	0	0	99.00
99.10 09910	CORF	0	0	0	0	99.10
101.00 10100	HOME HEALTH AGENCY	0	0	1,214	1,214	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
109.00 10900	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00 11000	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00 11100	ISLET ACQUISITION	0	0	0	0	111.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	20,144,948	10,143,886	30,288,834	118.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140213

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet B  
Part II  
Date/Time Prepared:  
2/26/2013 7:45 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	
		BLDG & FIXT	MVBLE EQUIP			
		1.00	2.00			
<b>NONREIMBURSABLE COST CENTERS</b>						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	144,134	0	144,134	11 190.00
192.00 19200	PHYSICIANS' PRIVATE OFFICES	0	27,730	0	27,730	0 192.00
200.00	Cross Foot Adjustments				0	0 200.00
201.00	Negative Cost Centers		0	0	0	0 201.00
202.00	TOTAL (sum lines 118-201)	0	20,316,812	10,143,886	30,460,698	88,918 202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 140213	Period: From 10/01/2011 To 09/30/2012	Worksheet B Part II Date/Time Prepared: 2/26/2013 7:45 am		
Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY
			5.00	7.00	8.00	9.00	10.00
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	8,431,336				5.00
7.00	00700	OPERATION OF PLANT	439,707	860,456			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	25,066	5,323	127,863		8.00
9.00	00900	HOUSEKEEPING	178,530	10,398	0	410,750	9.00
10.00	01000	DIETARY	47,877	41,147	1,087	20,008	885,281
11.00	01100	CAFETERIA	96,348	10,068	0	4,895	0
13.00	01300	NURSING ADMINISTRATION	93,555	5,155	0	2,507	0
14.00	01400	CENTRAL SERVICES & SUPPLY	68,648	36,471	693	17,734	0
15.00	01500	PHARMACY	216,282	13,436	0	6,533	0
16.00	01600	MEDICAL RECORDS & LIBRARY	118,257	7,880	0	3,831	0
17.00	01700	SOCIAL SERVICE	23,753	0	0	0	0
23.00	02300	PARAMED ED PRGM-(SPECIFY)	34,296	2,235	4,252	1,087	0
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	1,353,113	232,518	59,480	113,061	637,533
31.00	03100	INTENSIVE CARE UNIT	251,849	35,786	5,897	17,401	119,792
40.00	04000	SUBPROVIDER - I/PF	83,369	21,826	424	10,613	47,750
41.00	04100	SUBPROVIDER - I/RF	181,633	37,273	4,822	18,124	80,206
42.00	04200	SUBPROVIDER	0	0	0	0	0
43.00	04300	NURSERY	124,869	65,433	1,129	31,816	0
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0
45.00	04500	NURSING FACILITY	0	0	0	0	0
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	727,255	103,192	16,806	50,177	0
51.00	05100	RECOVERY ROOM	72,808	8,153	1,306	3,965	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	159,104	12,402	5,067	6,031	0
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	578,952	57,367	6,932	27,894	0
54.01	05401	ULTRASOUND	72,554	9,541	1,298	4,639	0
57.00	05700	CT SCAN	100,469	3,708	0	1,803	0
58.00	05800	MRI	59,572	4,780	210	2,324	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	366,864	10,443	81	5,078	0
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	75,915	394	0	192	0
65.00	06500	RESPIRATORY THERAPY	86,636	3,319	0	1,614	0
65.01	06501	SLEEP LAB	6,182	0	0	0	0
66.00	06600	PHYSICAL THERAPY	100,453	4,955	0	2,409	0
67.00	06700	OCCUPATIONAL THERAPY	79,874	2,441	2,762	1,187	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	65,521	2,988	64	1,453	0
70.00	07000	ELECTROENCEPHALOGRAPHY	12,421	3,071	36	1,493	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	450,536	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	622,294	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	372,425	0	0	0	0
74.00	07400	RENAL DIALYSIS	307,392	10,302	1,425	5,009	0
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00	09000	CLINIC	29,129	1,471	0	715	0
90.01	09001	HOMER GLEN LAB	27,994	6,168	0	2,999	0
90.02	09002	HOMER GLEN FEC	61,889	0	0	0	0
90.03	09003	WOMEN'S HEALTH	64,769	0	0	0	0
91.00	09100	EMERGENCY	400,589	71,846	14,092	34,935	0
91.01	09101	OP MENTAL HEALTH	31,726	8,349	0	4,060	0
91.02	09102	DIABETES CENTER	13,782	1,225	0	596	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
<b>OTHER REIMBURSABLE COST CENTERS</b>							
94.00	09400	HOME PROGRAM DIALYSIS	16,384	0	0	0	0
99.00	09900	CMHC	0	0	0	0	0
99.10	09910	CORF	0	0	0	0	0
101.00	10100	HOME HEALTH AGENCY	122,500	0	0	0	0
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0
111.00	11100	ISLET ACQUISITION	0	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	8,423,141	851,064	127,863	406,183	885,281
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	6,978	7,877	0	3,830	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	1,217	1,515	0	737	0
200.00		Cross Foot Adjustments					200.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140213			Period: From 10/01/2011 To 09/30/2012		Worksheet B Part II Date/Time Prepared: 2/26/2013 7:45 am	
Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY		
201.00	Negative Cost Centers	5.00	7.00	8.00	9.00	10.00	0	201.00
202.00	TOTAL (sum lines 118-201)	8,431,336	860,456	127,863	410,750	885,281	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140213		Period: From 10/01/2011 To 09/30/2012		Worksheet B Part II Date/Time Prepared: 2/26/2013 7:45 am	
Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	321,498					11.00
13.00	01300	6,179	250,168				13.00
14.00	01400	4,459	0	925,053			14.00
15.00	01500	7,634	0	7,023	499,038		15.00
16.00	01600	11,221	0	700	0	296,865	16.00
17.00	01700	1,752	0	0	0	0	17.00
23.00	02300	7,516	0	7,442	1,749	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	84,467	153,045	56,389	858	117,484	30.00
31.00	03100	12,495	22,642	12,940	260	36,163	31.00
40.00	04000	5,534	0	836	49	9,437	40.00
41.00	04100	9,662	17,504	3,392	0	9,178	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	3,475	6,294	6,165	35	12,688	43.00
44.00	04400	0	0	0	0	0	44.00
45.00	04500	0	0	0	0	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	28,115	0	79,947	3,735	0	50.00
51.00	05100	3,363	0	2,083	2	0	51.00
52.00	05200	8,555	15,501	8,190	70	0	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	26,469	0	29,273	1,059	0	54.00
54.01	05401	3,584	0	2,361	6	0	54.01
57.00	05700	3,575	0	7,329	10	0	57.00
58.00	05800	1,596	0	1,608	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	17,906	0	114,808	0	0	60.00
60.01	06001	0	0	0	0	0	60.01
63.00	06300	558	0	6,143	0	0	63.00
65.00	06500	5,693	0	9,102	0	0	65.00
65.01	06501	518	0	1,092	0	0	65.01
66.00	06600	5,396	0	1,098	9	27,328	66.00
67.00	06700	5,031	0	1,080	13	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	4,027	0	1,444	3	0	69.00
70.00	07000	817	0	191	0	6,348	70.00
71.00	07100	0	0	480,439	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	413,708	0	73.00
74.00	07400	11,981	21,706	34,488	75,398	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	1,073	0	1,196	0	1,198	90.00
90.01	09001	1,338	0	6,962	0	0	90.01
90.02	09002	3,098	0	3,137	431	0	90.02
90.03	09003	2,606	0	2,186	10	0	90.03
91.00	09100	22,839	0	23,449	620	77,041	91.00
91.01	09101	1,358	0	266	0	0	91.01
91.02	09102	1,576	2,854	276	0	0	91.02
92.00	09200	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
94.00	09400	0	0	10,165	987	0	94.00
99.00	09900	0	0	0	0	0	99.00
99.10	09910	0	0	0	0	0	99.10
101.00	10100	5,862	10,622	1,853	26	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	10900	0	0	0	0	0	109.00
110.00	11000	0	0	0	0	0	110.00
111.00	11100	0	0	0	0	0	111.00
118.00		321,328	250,168	925,053	499,038	296,865	118.00
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	170	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140213			Period: From 10/01/2011 To 09/30/2012		Worksheet B Part II Date/Time Prepared: 2/26/2013 7:45 am	
Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY		
		11.00	13.00	14.00	15.00	16.00		
200.00	Cross Foot Adjustments							200.00
201.00	Negative Cost Centers	0	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	321,498	250,168	925,053	499,038	296,865		202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140213

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet B  
Part II  
Date/Time Prepared:  
2/26/2013 7:45 am

Cost Center Description		SOCIAL SERVICE	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		17.00	23.00	24.00	25.00	26.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300						13.00
14.00	01400						14.00
15.00	01500						15.00
16.00	01600						16.00
17.00	01700	25,914					17.00
23.00	02300		130,628				23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	22,510		7,451,824	0	7,451,824	30.00
31.00	03100	1,380		1,295,500	0	1,295,500	31.00
40.00	04000	0		596,319	0	596,319	40.00
41.00	04100	0		1,066,406	0	1,066,406	41.00
42.00	04200	0		0	0	0	42.00
43.00	04300	0		1,542,641	0	1,542,641	43.00
44.00	04400	0		0	0	0	44.00
45.00	04500	0		0	0	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	0		4,084,389	0	4,084,389	50.00
51.00	05100	0		272,361	0	272,361	51.00
52.00	05200	0		625,559	0	625,559	52.00
53.00	05300	0		0	0	0	53.00
54.00	05400	0		3,494,335	0	3,494,335	54.00
54.01	05401	0		369,702	0	369,702	54.01
57.00	05700	0		565,421	0	565,421	57.00
58.00	05800	0		290,170	0	290,170	58.00
59.00	05900	0		0	0	0	59.00
60.00	06000	0		739,384	0	739,384	60.00
60.01	06001	0		0	0	0	60.01
63.00	06300	0		94,896	0	94,896	63.00
65.00	06500	0		214,898	0	214,898	65.00
65.01	06501	0		21,046	0	21,046	65.01
66.00	06600	0		266,149	0	266,149	66.00
67.00	06700	0		140,241	0	140,241	67.00
68.00	06800	0		0	0	0	68.00
69.00	06900	0		204,147	0	204,147	69.00
70.00	07000	0		80,788	0	80,788	70.00
71.00	07100	0		930,975	0	930,975	71.00
72.00	07200	0		622,294	0	622,294	72.00
73.00	07300	0		1,099,765	0	1,099,765	73.00
74.00	07400	0		718,044	0	718,044	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	0		0	0	0	88.00
89.00	08900	0		0	0	0	89.00
90.00	09000	322		63,746	0	63,746	90.00
90.01	09001	0		160,699	0	160,699	90.01
90.02	09002	0		102,273	0	102,273	90.02
90.03	09003	0		326,493	0	326,493	90.03
91.00	09100	1,702		2,278,766	0	2,278,766	91.00
91.01	09101	0		201,361	0	201,361	91.01
91.02	09102	0		44,149	0	44,149	91.02
92.00	09200	0		0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
94.00	09400	0		27,615	0	27,615	94.00
99.00	09900	0		0	0	0	99.00
99.10	09910	0		0	0	0	99.10
101.00	10100	0		143,515	0	143,515	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	10900	0		0	0	0	109.00
110.00	11000	0		0	0	0	110.00
111.00	11100	0		0	0	0	111.00
118.00		25,914	0	30,135,871	0	30,135,871	118.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140213

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet B  
Part II  
Date/Time Prepared:  
2/26/2013 7:45 am

Cost Center Description			SOCIAL SERVICE	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	23.00	24.00	25.00	26.00	
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		163,000	0	163,000	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		31,199	0	31,199	192.00
200.00		Cross Foot Adjustments		130,628	130,628	0	130,628	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	25,914	130,628	30,460,698	0	30,460,698	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140213

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet B-1  
Date/Time Prepared:  
2/26/2013 7:45 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
	1.00	2.00				
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 00100	CAP REL COSTS-BLDG & FIXT	470,377				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		9,967,868			2.00
4.00 00400	EMPLOYEE BENEFITS	1,964	4,017	88,216,840		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	97,999	4,114,448	11,314,169	-56,034,368	5.00
7.00 00700	OPERATION OF PLANT	5,902	160,263	2,710,844	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	2,255	0	74,222	0	8.00
9.00 00900	HOUSEKEEPING	4,405	29,166	1,862,836	0	9.00
10.00 01000	DIETARY	17,431	21,168	724,029	0	10.00
11.00 01100	CAFETERIA	4,265	24,684	844,304	0	11.00
13.00 01300	NURSING ADMINISTRATION	2,184	46,139	1,473,220	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	15,450	126,973	503,009	0	14.00
15.00 01500	PHARMACY	5,692	0	2,260,264	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	3,338	8,854	1,774,973	0	16.00
17.00 01700	SOCIAL SERVICE	0	0	405,696	0	17.00
23.00 02300	PARAMED PRGM-(SPECIFY)	947	30,294	316,356	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>						
30.00 03000	ADULTS & PEDIATRICS	98,499	342,603	18,142,223	0	30.00
31.00 03100	INTENSIVE CARE UNIT	15,160	118,542	3,432,797	0	31.00
40.00 04000	SUBPROVIDER - IPF	9,246	15,819	1,016,046	0	40.00
41.00 04100	SUBPROVIDER - IRF	15,790	20,031	2,198,554	0	41.00
42.00 04200	SUBPROVIDER	0	0	0	0	42.00
43.00 04300	NURSERY	27,719	90,975	892,009	0	43.00
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
45.00 04500	NURSING FACILITY	0	0	0	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00 05000	OPERATING ROOM	43,715	1,159,914	6,547,427	0	50.00
51.00 05100	RECOVERY ROOM	3,454	29,892	1,065,499	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	5,254	178,370	2,167,462	0	52.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	24,302	1,681,251	5,736,367	0	54.00
54.01 05401	ULTRASOUND	4,042	98,430	958,778	0	54.01
57.00 05700	CT SCAN	1,571	373,163	910,612	0	57.00
58.00 05800	MRI	2,025	129,823	494,752	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00 06000	LABORATORY	4,424	29,362	3,213,223	0	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	60.01
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	167	4,282	122,132	0	63.00
65.00 06500	RESPIRATORY THERAPY	1,406	45,824	1,162,361	0	65.00
65.01 06501	SLEEP LAB	0	12,934	90,956	0	65.01
66.00 06600	PHYSICAL THERAPY	2,099	31,993	1,271,962	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	1,034	1,968	1,179,158	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00 06900	ELECTROCARDIOLOGY	1,266	71,779	910,983	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	1,301	52	162,371	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	308,190	0	0	73.00
74.00 07400	RENAL DIALYSIS	4,364	57,810	2,995,228	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00 09000	CLINIC	623	1,394	311,777	0	90.00
90.01 09001	HOMER GLEN LAB	2,613	2,067	269,723	0	90.01
90.02 09002	HOMER GLEN FEC	0	32,331	809,266	0	90.02
90.03 09003	WOMEN'S HEALTH	0	251,874	595,391	0	90.03
91.00 09100	EMERGENCY	30,436	306,520	5,069,102	0	91.00
91.01 09101	OP MENTAL HEALTH	3,537	2,275	510,649	0	91.01
91.02 09102	DIABETES CENTER	519	1,201	199,447	0	91.02
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
94.00 09400	HOME PROGRAM DIALYSIS	0	0	78,774	0	94.00
99.00 09900	CMHC	0	0	0	0	99.00
99.10 09910	CORF	0	0	0	0	99.10
101.00 10100	HOME HEALTH AGENCY	0	1,193	1,426,805	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>						
109.00 10900	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00 11000	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00 11100	ISLET ACQUISITION	0	0	0	0	111.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	466,398	9,967,868	88,205,756	-56,034,368	118.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140213

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet B-1

Date/Time Prepared:  
2/26/2013 7:45 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)			
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)						
	1.00	2.00					4.00	5A
<b>NONREIMBURSABLE COST CENTERS</b>								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,337	0	11,084	0	159,000	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	642	0	0	0	27,730	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)	20,316,812	10,143,886	29,472,304		56,034,368	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	43.192614	1.017659	0.334089		0.291675	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			88,918		8,431,336	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001008		0.043887	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140213

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet B-1

Date/Time Prepared:  
2/26/2013 7:45 am

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (NUMBER HOUSED)	
		7.00	8.00	9.00	10.00	11.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	364,512				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,255	1,781,943			8.00
9.00	00900	HOUSEKEEPING	4,405	0	357,852		9.00
10.00	01000	DIETARY	17,431	15,151	17,431	350,774	10.00
11.00	01100	CAFETERIA	4,265	0	4,265	0	111,768
13.00	01300	NURSING ADMINISTRATION	2,184	0	2,184	0	2,148
14.00	01400	CENTRAL SERVICES & SUPPLY	15,450	9,661	15,450	0	1,550
15.00	01500	PHARMACY	5,692	0	5,692	0	2,654
16.00	01600	MEDICAL RECORDS & LIBRARY	3,338	0	3,338	0	3,901
17.00	01700	SOCIAL SERVICE	0	0	0	0	609
23.00	02300	PARAMED ED PRGM-(SPECIFY)	947	59,253	947	0	2,613
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	98,499	828,918	98,499	252,609	29,365
31.00	03100	INTENSIVE CARE UNIT	15,160	82,180	15,160	47,465	4,344
40.00	04000	SUBPROVIDER - I/PF	9,246	5,912	9,246	18,920	1,924
41.00	04100	SUBPROVIDER - I/RF	15,790	67,206	15,790	31,780	3,359
42.00	04200	SUBPROVIDER	0	0	0	0	0
43.00	04300	NURSERY	27,719	15,737	27,719	0	1,208
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0
45.00	04500	NURSING FACILITY	0	0	0	0	0
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	43,715	234,211	43,715	0	9,774
51.00	05100	RECOVERY ROOM	3,454	18,195	3,454	0	1,169
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,254	70,622	5,254	0	2,974
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	24,302	96,601	24,302	0	9,202
54.01	05401	ULTRASOUND	4,042	18,090	4,042	0	1,246
57.00	05700	CT SCAN	1,571	0	1,571	0	1,243
58.00	05800	MRI	2,025	2,931	2,025	0	555
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	4,424	1,130	4,424	0	6,225
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	167	0	167	0	194
65.00	06500	RESPIRATORY THERAPY	1,406	0	1,406	0	1,979
65.01	06501	SLEEP LAB	0	0	0	0	180
66.00	06600	PHYSICAL THERAPY	2,099	0	2,099	0	1,876
67.00	06700	OCCUPATIONAL THERAPY	1,034	38,496	1,034	0	1,749
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	1,266	888	1,266	0	1,400
70.00	07000	ELECTROENCEPHALOGRAPHY	1,301	507	1,301	0	284
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
74.00	07400	RENAL DIALYSIS	4,364	19,861	4,364	0	4,165
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00	09000	CLINIC	623	0	623	0	373
90.01	09001	HOMER GLEN LAB	2,613	0	2,613	0	465
90.02	09002	HOMER GLEN FEC	0	0	0	0	1,077
90.03	09003	WOMEN'S HEALTH	0	0	0	0	906
91.00	09100	EMERGENCY	30,436	196,393	30,436	0	7,940
91.01	09101	OP MENTAL HEALTH	3,537	0	3,537	0	472
91.02	09102	DIABETES CENTER	519	0	519	0	548
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
<b>OTHER REIMBURSABLE COST CENTERS</b>							
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0
99.00	09900	CMHC	0	0	0	0	0
99.10	09910	CORF	0	0	0	0	0
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	2,038
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0
111.00	11100	ISLET ACQUISITION	0	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	360,533	1,781,943	353,873	350,774	111,709
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	3,337	0	3,337	0	59

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140213

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet B-1

Date/Time Prepared:  
2/26/2013 7:45 am

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (NUMBER HOUSED)	
		7.00	8.00	9.00	10.00	11.00	
192.00	19200	PHYSICIANS' PRIVATE OFFICES	642	0	642	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)	12,941,378	817,807	5,410,872	2,298,475	3,051,617
203.00		Unit cost multiplier (Wkst. B, Part I)	35.503298	0.458941	15.120418	6.552581	27.303137
204.00		Cost to be allocated (per Wkst. B, Part II)	860,456	127,863	410,750	885,281	321,498
205.00		Unit cost multiplier (Wkst. B, Part II)	2.360570	0.071755	1.147821	2.523793	2.876476

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140213

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet B-1  
Date/Time Prepared:  
2/26/2013 7:45 am

Cost Center Description		NURSING ADMINISTRATION  (DIRECT NURSING)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE  (TIME SPENT)	
		13.00	14.00	15.00	16.00	17.00	
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300	998,417					13.00
14.00	01400	0	19,766,157				14.00
15.00	01500	0	150,058	9,857,944			15.00
16.00	01600	0	14,962	0	38,911		16.00
17.00	01700	0	0	0	0	2,816	17.00
23.00	02300	0	159,012	34,552	0	0	23.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	610,797	1,204,889	16,952	15,399	2,446	30.00
31.00	03100	90,363	276,496	5,139	4,740	150	31.00
40.00	04000	0	17,873	976	1,237	0	40.00
41.00	04100	69,860	72,479	0	1,203	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	25,118	131,731	686	1,663	0	43.00
44.00	04400	0	0	0	0	0	44.00
45.00	04500	0	0	0	0	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	0	1,708,271	73,778	0	0	50.00
51.00	05100	0	44,501	42	0	0	51.00
52.00	05200	61,866	175,003	1,378	0	0	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	0	625,483	20,921	0	0	54.00
54.01	05401	0	50,439	122	0	0	54.01
57.00	05700	0	156,608	189	0	0	57.00
58.00	05800	0	34,365	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	0	2,453,169	0	0	0	60.00
60.01	06001	0	0	0	0	0	60.01
63.00	06300	0	131,264	0	0	0	63.00
65.00	06500	0	194,489	0	0	0	65.00
65.01	06501	0	23,343	0	0	0	65.01
66.00	06600	0	23,452	172	3,582	0	66.00
67.00	06700	0	23,083	252	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	0	30,852	64	0	0	69.00
70.00	07000	0	4,083	0	832	0	70.00
71.00	07100	0	10,265,827	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	8,172,365	0	0	73.00
74.00	07400	86,629	736,931	1,489,396	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	0	25,562	0	157	35	90.00
90.01	09001	0	148,766	0	0	0	90.01
90.02	09002	0	67,035	8,523	0	0	90.02
90.03	09003	0	46,714	197	0	0	90.03
91.00	09100	0	501,052	12,238	10,098	185	91.00
91.01	09101	0	5,691	0	0	0	91.01
91.02	09102	11,391	5,889	0	0	0	91.02
92.00	09200	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
94.00	09400	0	217,194	19,492	0	0	94.00
99.00	09900	0	0	0	0	0	99.00
99.10	09910	0	0	0	0	0	99.10
101.00	10100	42,393	39,591	510	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	10900	0	0	0	0	0	109.00
110.00	11000	0	0	0	0	0	110.00
111.00	11100	0	0	0	0	0	111.00
118.00		998,417	19,766,157	9,857,944	38,911	2,816	118.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140213

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet B-1

Date/Time Prepared:  
2/26/2013 7:45 am

Cost Center Description		NURSING ADMINISTRATION  (DIRECT NURSING)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE  (TIME SPENT)	
		13.00	14.00	15.00	16.00	17.00	
<b>NONREIMBURSABLE COST CENTERS</b>							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	2,922,717	2,849,331	6,747,811	3,758,159	715,728
203.00		Unit cost multiplier (Wkst. B, Part I)	2.927351	0.144152	0.684505	96.583460	254.164773
204.00		Cost to be allocated (per Wkst. B, Part II)	250,168	925,053	499,038	296,865	25,914
205.00		Unit cost multiplier (Wkst. B, Part II)	0.250565	0.046800	0.050623	7.629334	9.202415

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140213

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet B-1  
Date/Time Prepared:  
2/26/2013 7:45 am

Cost Center Description		PARAMED ED PRGM (ASSIGNED TIME)	
		23.00	
<b>GENERAL SERVICE COST CENTERS</b>			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS	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-(SPECIFY)	23.00
		4,487	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
40.00	04000	SUBPROVIDER - I PF	40.00
41.00	04100	SUBPROVIDER - I RF	41.00
42.00	04200	SUBPROVIDER	42.00
43.00	04300	NURSERY	43.00
44.00	04400	SKILLED NURSING FACILITY	44.00
45.00	04500	NURSING FACILITY	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>			
50.00	05000	OPERATING ROOM	50.00
51.00	05100	RECOVERY ROOM	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
54.01	05401	ULTRASOUND	54.01
57.00	05700	CT SCAN	57.00
58.00	05800	MRI	58.00
59.00	05900	CARDIAC CATHETERIZATION	59.00
60.00	06000	LABORATORY	60.00
60.01	06001	BLOOD LABORATORY	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	63.00
65.00	06500	RESPIRATORY THERAPY	65.00
65.01	06501	SLEEP LAB	65.01
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
74.00	07400	RENAL DIALYSIS	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>			
88.00	08800	RURAL HEALTH CLINIC	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	89.00
90.00	09000	CLINIC	90.00
90.01	09001	HOMER GLEN LAB	90.01
90.02	09002	HOMER GLEN FEC	90.02
90.03	09003	WOMEN'S HEALTH	90.03
91.00	09100	EMERGENCY	91.00
91.01	09101	OP MENTAL HEALTH	91.01
91.02	09102	DIABETES CENTER	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>			
94.00	09400	HOME PROGRAM DIALYSIS	94.00
99.00	09900	CMHC	99.00
99.10	09910	CORF	99.10
101.00	10100	HOME HEALTH AGENCY	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>			
109.00	10900	PANCREAS ACQUISITION	109.00
110.00	11000	INTESTINAL ACQUISITION	110.00
111.00	11100	ISLET ACQUISITION	111.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	118.00
		4,487	
<b>NONREIMBURSABLE COST CENTERS</b>			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140213

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet B-1  
Date/Time Prepared:  
2/26/2013 7:45 am

Cost Center Description		PARAMED ED PRGM (ASSIGNED TIME)	
		23.00	
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	192.00
200.00	Cross Foot Adjustments		200.00
201.00	Negative Cost Centers		201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	1,202,458	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	267.987074	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	130,628	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	29.112547	205.00

Provider CCN: 140213

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet B-2

Date/Time Prepared:  
2/26/2013 7:45 am

	Description	Worksheet		Amount	
		Part	Line No.		
1.00	ADJ FOR EPO COSTS IN RENAL DIALYSIS	2.00	3.00	74.00	0 1.00
2.00	ADJ FOR EPO COSTS IN HOME PROGRAM			94.00	0 2.00
3.00	ADJ FOR ARANESP COSTS IN RENAL DIALYSIS			74.00	0 3.00
4.00	ADJ FOR ARANESP COSTS IN HOME PROGRAM			94.00	0 4.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140213

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet C  
Part I  
Date/Time Prepared:  
2/26/2013 7:45 am

		Title XVIIII		Hospital		PPS	
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	
				Total Costs	RCE Disallowance		
		1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS	51,727,988		51,727,988	0	51,727,988	30.00
31.00	03100 INTENSIVE CARE UNIT	9,500,318		9,500,318	8,450	9,508,768	31.00
40.00	04000 SUBPROVIDER - I/PF	3,223,704		3,223,704	0	3,223,704	40.00
41.00	04100 SUBPROVIDER - I/RF	6,807,074		6,807,074	0	6,807,074	41.00
42.00	04200 SUBPROVIDER	0		0	0	0	42.00
43.00	04300 NURSERY	5,372,173		5,372,173	0	5,372,173	43.00
44.00	04400 SKILLED NURSING FACILITY	0		0	0	0	44.00
45.00	04500 NURSING FACILITY	0		0	0	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	24,288,577		24,288,577	2,504	24,291,081	50.00
51.00	05100 RECOVERY ROOM	2,364,443		2,364,443	0	2,364,443	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	5,269,579		5,269,579	0	5,269,579	52.00
53.00	05300 ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	18,669,952		18,669,952	0	18,669,952	54.00
54.01	05401 ULTRASOUND	2,389,696		2,389,696	0	2,389,696	54.01
57.00	05700 CT SCAN	3,093,166		3,093,166	0	3,093,166	57.00
58.00	05800 MRI	1,877,281		1,877,281	0	1,877,281	58.00
59.00	05900 CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000 LABORATORY	11,571,280		11,571,280	10,398	11,581,678	60.00
60.01	06001 BLOOD LABORATORY	0		0	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	2,266,985		2,266,985	0	2,266,985	63.00
65.00	06500 RESPIRATORY THERAPY	2,769,564	0	2,769,564	8,993	2,778,557	65.00
65.01	06501 SLEEP LAB	190,242	0	190,242	0	190,242	65.01
66.00	06600 PHYSICAL THERAPY	3,463,465	0	3,463,465	0	3,463,465	66.00
67.00	06700 OCCUPATIONAL THERAPY	2,472,097	0	2,472,097	0	2,472,097	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	2,059,186		2,059,186	0	2,059,186	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	520,376		520,376	0	520,376	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	14,739,952		14,739,952	0	14,739,952	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	18,315,241		18,315,241	0	18,315,241	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	16,555,173		16,555,173	0	16,555,173	73.00
74.00	07400 RENAL DIALYSIS	10,770,182		10,770,182	47,270	10,817,452	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0		0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000 CLINIC	926,775		926,775	0	926,775	90.00
90.01	09001 HOMER GLEN LAB	990,335		990,335	0	990,335	90.01
90.02	09002 HOMER GLEN FEC	1,866,403		1,866,403	0	1,866,403	90.02
90.03	09003 WOMEN'S HEALTH	1,937,864		1,937,864	0	1,937,864	90.03
91.00	09100 EMERGENCY	15,716,442		15,716,442	24,018	15,740,460	91.00
91.01	09101 OP MENTAL HEALTH	1,126,528		1,126,528	0	1,126,528	91.01
91.02	09102 DIABETES CENTER	481,064		481,064	63	481,127	91.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	5,450,455		5,450,455	0	5,450,455	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
94.00	09400 HOME PROGRAM DIALYSIS	526,853		526,853	0	526,853	94.00
99.00	09900 CMHC	0		0	0	0	99.00
99.10	09910 CORF	0		0	0	0	99.10
101.00	10100 HOME HEALTH AGENCY	3,852,835		3,852,835	0	3,852,835	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	10900 PANCREAS ACQUISITION	0		0	0	0	109.00
110.00	11000 INTestinal ACQUISITION	0		0	0	0	110.00
111.00	11100 ISLET ACQUISITION	0		0	0	0	111.00
200.00	Subtotal (see instructions)	253,153,248	0	253,153,248	101,696	253,254,944	200.00
201.00	Less Observation Beds	5,450,455		5,450,455	0	5,450,455	201.00
202.00	Total (see instructions)	247,702,793	0	247,702,793	101,696	247,804,489	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140213

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet C  
Part I  
Date/Time Prepared:  
2/26/2013 7:45 am

		Title XVIIII			Hospital	PPS	
Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000	ADULTS & PEDIATRICS	48,990,575		48,990,575		30.00
31.00	03100	INTENSIVE CARE UNIT	9,205,354		9,205,354		31.00
40.00	04000	SUBPROVIDER - IPF	3,669,397		3,669,397		40.00
41.00	04100	SUBPROVIDER - IRF	6,163,423		6,163,423		41.00
42.00	04200	SUBPROVIDER	0		0		42.00
43.00	04300	NURSERY	5,939,196		5,939,196		43.00
44.00	04400	SKILLED NURSING FACILITY	0		0		44.00
45.00	04500	NURSING FACILITY	0		0		45.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	49,669,665	70,968,811	120,638,476	0.201334	50.00
51.00	05100	RECOVERY ROOM	5,835,285	8,082,878	13,918,163	0.169882	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,196,444	869,283	7,065,727	0.745794	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	29,669,285	54,834,533	84,503,818	0.220936	54.00
54.01	05401	ULTRASOUND	5,784,585	14,300,161	20,084,746	0.118981	54.01
57.00	05700	CT SCAN	18,240,011	39,828,328	58,068,339	0.053268	57.00
58.00	05800	MRI	6,206,700	15,598,624	21,805,324	0.086093	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	54,756,495	78,884,408	133,640,903	0.086585	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	6,378,816	2,130,972	8,509,788	0.266397	63.00
65.00	06500	RESPIRATORY THERAPY	17,360,060	2,484,536	19,844,596	0.139563	65.00
65.01	06501	SLEEP LAB	0	1,141,385	1,141,385	0.166676	65.01
66.00	06600	PHYSICAL THERAPY	5,300,921	3,586,173	8,887,094	0.389719	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,219,683	6,685,044	9,904,727	0.249588	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	8,261,891	5,721,520	13,983,411	0.147259	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	654,710	1,389,625	2,044,335	0.254545	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	22,288,766	12,902,333	35,191,099	0.418855	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	22,318,479	10,076,563	32,395,042	0.565372	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	35,316,582	13,346,449	48,663,031	0.340200	73.00
74.00	07400	RENAL DIALYSIS	3,005,282	33,622,595	36,627,877	0.294043	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	09000	CLINIC	2,527	503,599	506,126	1.831115	90.00
90.01	09001	HOMER GLEN LAB	388,618	3,981,060	4,369,678	0.226638	90.01
90.02	09002	HOMER GLEN FEC	663,239	8,988,126	9,651,365	0.193382	90.02
90.03	09003	WOMEN'S HEALTH	537	4,363,695	4,364,232	0.444033	90.03
91.00	09100	EMERGENCY	16,476,715	46,762,151	63,238,866	0.248525	91.00
91.01	09101	OP MENTAL HEALTH	0	719,777	719,777	1.565107	91.01
91.02	09102	DIABETES CENTER	55,756	269,240	324,996	1.480215	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,107,356	4,711,681	5,819,037	0.936659	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
94.00	09400	HOME PROGRAM DIALYSIS	0	3,220,420	3,220,420	0.163598	94.00
99.00	09900	CMHC	0	0	0		99.00
99.10	09910	CORF	0	0	0		99.10
101.00	10100	HOME HEALTH AGENCY	0	4,530,493	4,530,493		101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	10900	PANCREAS ACQUISITION	0	0	0		109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0		110.00
111.00	11100	ISLET ACQUISITION	0	0	0		111.00
200.00		Subtotal (see instructions)	393,126,353	454,504,463	847,630,816		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	393,126,353	454,504,463	847,630,816		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140213	Period: From 10/01/2011 To 09/30/2012	Worksheet C Part I Date/Time Prepared: 2/26/2013 7:45 am
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital PPS
	INPATIENT ROUTINE SERVICE COST CENTERS	11.00		
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
40.00	04000 SUBPROVIDER - I PF			40.00
41.00	04100 SUBPROVIDER - I RF			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	0.201354		50.00
51.00	05100 RECOVERY ROOM	0.169882		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.745794		52.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.220936		54.00
54.01	05401 ULTRASOUND	0.118981		54.01
57.00	05700 CT SCAN	0.053268		57.00
58.00	05800 MRI	0.086093		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000 LABORATORY	0.086663		60.00
60.01	06001 BLOOD LABORATORY	0.000000		60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.266397		63.00
65.00	06500 RESPIRATORY THERAPY	0.140016		65.00
65.01	06501 SLEEP LAB	0.166676		65.01
66.00	06600 PHYSICAL THERAPY	0.389719		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.249588		67.00
68.00	06800 SPEECH PATHOLOGY	0.000000		68.00
69.00	06900 ELECTROCARDIOLOGY	0.147259		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.254545		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.418855		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.565372		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.340200		73.00
74.00	07400 RENAL DIALYSIS	0.295334		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	1.831115		90.00
90.01	09001 HOMER GLEN LAB	0.226638		90.01
90.02	09002 HOMER GLEN FEC	0.193382		90.02
90.03	09003 WOMEN'S HEALTH	0.444033		90.03
91.00	09100 EMERGENCY	0.248905		91.00
91.01	09101 OP MENTAL HEALTH	1.565107		91.01
91.02	09102 DIABETES CENTER	1.480409		91.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.936659		92.00
	OTHER REIMBURSABLE COST CENTERS			
94.00	09400 HOME PROGRAM DIALYSIS	0.163598		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: 140213

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet C  
Part I  
Date/Time Prepared:  
2/26/2013 7:45 am

		Title XIX		Hospital		PPS	
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs	
				Total Costs	RCE Disallowance		
		1.00	2.00	3.00	4.00	5.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS	51,727,988		51,727,988	0	51,727,988	30.00
31.00	03100 INTENSIVE CARE UNIT	9,500,318		9,500,318	8,450	9,508,768	31.00
40.00	04000 SUBPROVIDER - I/PF	3,223,704		3,223,704	0	3,223,704	40.00
41.00	04100 SUBPROVIDER - I/RF	6,807,074		6,807,074	0	6,807,074	41.00
42.00	04200 SUBPROVIDER	0		0	0	0	42.00
43.00	04300 NURSERY	5,372,173		5,372,173	0	5,372,173	43.00
44.00	04400 SKILLED NURSING FACILITY	0		0	0	0	44.00
45.00	04500 NURSING FACILITY	0		0	0	0	45.00
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	24,288,577		24,288,577	2,504	24,291,081	50.00
51.00	05100 RECOVERY ROOM	2,364,443		2,364,443	0	2,364,443	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	5,269,579		5,269,579	0	5,269,579	52.00
53.00	05300 ANESTHESIOLOGY	0		0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	18,669,952		18,669,952	0	18,669,952	54.00
54.01	05401 ULTRASOUND	2,389,696		2,389,696	0	2,389,696	54.01
57.00	05700 CT SCAN	3,093,166		3,093,166	0	3,093,166	57.00
58.00	05800 MRI	1,877,281		1,877,281	0	1,877,281	58.00
59.00	05900 CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000 LABORATORY	11,571,280		11,571,280	10,398	11,581,678	60.00
60.01	06001 BLOOD LABORATORY	0		0	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	2,266,985		2,266,985	0	2,266,985	63.00
65.00	06500 RESPIRATORY THERAPY	2,769,564	0	2,769,564	8,993	2,778,557	65.00
65.01	06501 SLEEP LAB	190,242	0	190,242	0	190,242	65.01
66.00	06600 PHYSICAL THERAPY	3,463,465	0	3,463,465	0	3,463,465	66.00
67.00	06700 OCCUPATIONAL THERAPY	2,472,097	0	2,472,097	0	2,472,097	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	2,059,186		2,059,186	0	2,059,186	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	520,376		520,376	0	520,376	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	14,739,952		14,739,952	0	14,739,952	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	18,315,241		18,315,241	0	18,315,241	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	16,555,173		16,555,173	0	16,555,173	73.00
74.00	07400 RENAL DIALYSIS	10,770,182		10,770,182	47,270	10,817,452	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0		0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000 CLINIC	926,775		926,775	0	926,775	90.00
90.01	09001 HOMER GLEN LAB	990,335		990,335	0	990,335	90.01
90.02	09002 HOMER GLEN FEC	1,866,403		1,866,403	0	1,866,403	90.02
90.03	09003 WOMEN'S HEALTH	1,937,864		1,937,864	0	1,937,864	90.03
91.00	09100 EMERGENCY	15,716,442		15,716,442	24,018	15,740,460	91.00
91.01	09101 OP MENTAL HEALTH	1,126,528		1,126,528	0	1,126,528	91.01
91.02	09102 DIABETES CENTER	481,064		481,064	63	481,127	91.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	5,450,455		5,450,455	0	5,450,455	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
94.00	09400 HOME PROGRAM DIALYSIS	526,853		526,853	0	526,853	94.00
99.00	09900 CMHC	0		0	0	0	99.00
99.10	09910 CORF	0		0	0	0	99.10
101.00	10100 HOME HEALTH AGENCY	3,852,835		3,852,835	0	3,852,835	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>							
109.00	10900 PANCREAS ACQUISITION	0		0	0	0	109.00
110.00	11000 INTestinal ACQUISITION	0		0	0	0	110.00
111.00	11100 ISLET ACQUISITION	0		0	0	0	111.00
200.00	Subtotal (see instructions)	253,153,248	0	253,153,248	101,696	253,254,944	200.00
201.00	Less Observation Beds	5,450,455		5,450,455	0	5,450,455	201.00
202.00	Total (see instructions)	247,702,793	0	247,702,793	101,696	247,804,489	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140213

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet C  
Part I  
Date/Time Prepared:  
2/26/2013 7:45 am

		Title XIX			Hospital	PPS		
Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
		Inpatient	Outpatient	Total (col. 6 + col. 7)				
		6.00	7.00	8.00				9.00
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	48,990,575		48,990,575			30.00
31.00	03100	INTENSIVE CARE UNIT	9,205,354		9,205,354			31.00
40.00	04000	SUBPROVIDER - IPF	3,669,397		3,669,397			40.00
41.00	04100	SUBPROVIDER - IRF	6,163,423		6,163,423			41.00
42.00	04200	SUBPROVIDER	0		0			42.00
43.00	04300	NURSERY	5,939,196		5,939,196			43.00
44.00	04400	SKILLED NURSING FACILITY	0		0			44.00
45.00	04500	NURSING FACILITY	0		0			45.00
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	49,669,665	70,968,811	120,638,476	0.201334	0.000000	50.00
51.00	05100	RECOVERY ROOM	5,835,285	8,082,878	13,918,163	0.169882	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,196,444	869,283	7,065,727	0.745794	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	29,669,285	54,834,533	84,503,818	0.220936	0.000000	54.00
54.01	05401	ULTRASOUND	5,784,585	14,300,161	20,084,746	0.118981	0.000000	54.01
57.00	05700	CT SCAN	18,240,011	39,828,328	58,068,339	0.053268	0.000000	57.00
58.00	05800	MRI	6,206,700	15,598,624	21,805,324	0.086093	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	0.000000	59.00
60.00	06000	LABORATORY	54,756,495	78,884,408	133,640,903	0.086585	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.	6,378,816	2,130,972	8,509,788	0.266397	0.000000	63.00
65.00	06500	RESPIRATORY THERAPY	17,360,060	2,484,536	19,844,596	0.139563	0.000000	65.00
65.01	06501	SLEEP LAB	0	1,141,385	1,141,385	0.166676	0.000000	65.01
66.00	06600	PHYSICAL THERAPY	5,300,921	3,586,173	8,887,094	0.389719	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,219,683	6,685,044	9,904,727	0.249588	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	8,261,891	5,721,520	13,983,411	0.147259	0.000000	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	654,710	1,389,625	2,044,335	0.254545	0.000000	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	22,288,766	12,902,333	35,191,099	0.418855	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	22,318,479	10,076,563	32,395,042	0.565372	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	35,316,582	13,346,449	48,663,031	0.340200	0.000000	73.00
74.00	07400	RENAL DIALYSIS	3,005,282	33,622,595	36,627,877	0.294043	0.000000	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
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	2,527	503,599	506,126	1.831115	0.000000	90.00
90.01	09001	HOMER GLEN LAB	388,618	3,981,060	4,369,678	0.226638	0.000000	90.01
90.02	09002	HOMER GLEN FEC	663,239	8,988,126	9,651,365	0.193382	0.000000	90.02
90.03	09003	WOMEN'S HEALTH	537	4,363,695	4,364,232	0.444033	0.000000	90.03
91.00	09100	EMERGENCY	16,476,715	46,762,151	63,238,866	0.248525	0.000000	91.00
91.01	09101	OP MENTAL HEALTH	0	719,777	719,777	1.565107	0.000000	91.01
91.02	09102	DIABETES CENTER	55,756	269,240	324,996	1.480215	0.000000	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,107,356	4,711,681	5,819,037	0.936659	0.000000	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
94.00	09400	HOME PROGRAM DIALYSIS	0	3,220,420	3,220,420	0.163598	0.000000	94.00
99.00	09900	CMHC	0	0	0			99.00
99.10	09910	CORF	0	0	0			99.10
101.00	10100	HOME HEALTH AGENCY	0	4,530,493	4,530,493			101.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
109.00	10900	PANCREAS ACQUISITION	0	0	0			109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0			110.00
111.00	11100	ISLET ACQUISITION	0	0	0			111.00
200.00		Subtotal (see instructions)	393,126,353	454,504,463	847,630,816			200.00
201.00		Less Observation Beds						201.00
202.00		Total (see instructions)	393,126,353	454,504,463	847,630,816			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES			Provider CCN: 140213	Period: From 10/01/2011 To 09/30/2012	Worksheet C Part I Date/Time Prepared: 2/26/2013 7:45 am
			Title XIX	Hospital	PPS
Cost Center Description			PPS Inpatient Ratio		
			11.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS			30.00
31.00	03100	INTENSIVE CARE UNIT			31.00
40.00	04000	SUBPROVIDER - I PF			40.00
41.00	04100	SUBPROVIDER - I RF			41.00
42.00	04200	SUBPROVIDER			42.00
43.00	04300	NURSERY			43.00
44.00	04400	SKILLED NURSING FACILITY			44.00
45.00	04500	NURSING FACILITY			45.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.201354		50.00
51.00	05100	RECOVERY ROOM	0.169882		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.745794		52.00
53.00	05300	ANESTHESIOLOGY	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.220936		54.00
54.01	05401	ULTRASOUND	0.118981		54.01
57.00	05700	CT SCAN	0.053268		57.00
58.00	05800	MRI	0.086093		58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000	LABORATORY	0.086663		60.00
60.01	06001	BLOOD LABORATORY	0.000000		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.266397		63.00
65.00	06500	RESPIRATORY THERAPY	0.140016		65.00
65.01	06501	SLEEP LAB	0.166676		65.01
66.00	06600	PHYSICAL THERAPY	0.389719		66.00
67.00	06700	OCCUPATIONAL THERAPY	0.249588		67.00
68.00	06800	SPEECH PATHOLOGY	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	0.147259		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.254545		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.418855		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.565372		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.340200		73.00
74.00	07400	RENAL DIALYSIS	0.295334		74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
90.00	09000	CLINIC	1.831115		90.00
90.01	09001	HOMER GLEN LAB	0.226638		90.01
90.02	09002	HOMER GLEN FEC	0.193382		90.02
90.03	09003	WOMEN'S HEALTH	0.444033		90.03
91.00	09100	EMERGENCY	0.248905		91.00
91.01	09101	OP MENTAL HEALTH	1.565107		91.01
91.02	09102	DIABETES CENTER	1.480409		91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.936659		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
94.00	09400	HOME PROGRAM DIALYSIS	0.163598		94.00
99.00	09900	CMHC			99.00
99.10	09910	CORF			99.10
101.00	10100	HOME HEALTH AGENCY			101.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
109.00	10900	PANCREAS ACQUISITION			109.00
110.00	11000	INTESTINAL ACQUISITION			110.00
111.00	11100	ISLET ACQUISITION			111.00
200.00		Subtotal (see instructions)			200.00
201.00		Less Observation Beds			201.00
202.00		Total (see instructions)			202.00

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

Provider CCN: 140213

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet C  
Part II  
Date/Time Prepared:  
2/26/2013 7:45 am

Cost Center Description			Title XIX			Hospital	PPS	
			Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount	
			1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	24,288,577	4,084,389	20,204,188	0	0	50.00
51.00	05100	RECOVERY ROOM	2,364,443	272,361	2,092,082	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	5,269,579	625,559	4,644,020	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	18,669,952	3,494,335	15,175,617	0	0	54.00
54.01	05401	ULTRASOUND	2,389,696	369,702	2,019,994	0	0	54.01
57.00	05700	CT SCAN	3,093,166	565,421	2,527,745	0	0	57.00
58.00	05800	MRI	1,877,281	290,170	1,587,111	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	11,571,280	739,384	10,831,896	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,266,985	94,896	2,172,089	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	2,769,564	214,898	2,554,666	0	0	65.00
65.01	06501	SLEEP LAB	190,242	21,046	169,196	0	0	65.01
66.00	06600	PHYSICAL THERAPY	3,463,465	266,149	3,197,316	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,472,097	140,241	2,331,856	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,059,186	204,147	1,855,039	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	520,376	80,788	439,588	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	14,739,952	930,975	13,808,977	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	18,315,241	622,294	17,692,947	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	16,555,173	1,099,765	15,455,408	0	0	73.00
74.00	07400	RENAL DIALYSIS	10,770,182	718,044	10,052,138	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	926,775	63,746	863,029	0	0	90.00
90.01	09001	HOMER GLEN LAB	990,335	160,699	829,636	0	0	90.01
90.02	09002	HOMER GLEN FEC	1,866,403	102,273	1,764,130	0	0	90.02
90.03	09003	WOMEN'S HEALTH	1,937,864	326,493	1,611,371	0	0	90.03
91.00	09100	EMERGENCY	15,716,442	2,278,766	13,437,676	0	0	91.00
91.01	09101	OP MENTAL HEALTH	1,126,528	201,361	925,167	0	0	91.01
91.02	09102	DIABETES CENTER	481,064	44,149	436,915	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	5,450,455	785,182	4,665,273	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
94.00	09400	HOME PROGRAM DIALYSIS	526,853	27,615	499,238	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	3,852,835	143,515	3,709,320	0	0	101.00
<b>SPECIAL PURPOSE COST CENTERS</b>								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
200.00		Subtotal (sum of lines 50 thru 199)	176,521,991	18,968,363	157,553,628	0	0	200.00
201.00		Less Observation Beds	5,450,455	785,182	4,665,273	0	0	201.00
202.00		Total (Line 200 minus Line 201)	171,071,536	18,183,181	152,888,355	0	0	202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY		Provider CCN: 140213	Period: From 10/01/2011 To 09/30/2012	Worksheet C Part II Date/Time Prepared: 2/26/2013 7:45 am
		Title XIX	Hospital	PPS

Cost Center Description	Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)		
	6.00	7.00	8.00		
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00 05000 OPERATING ROOM	24,288,577	120,638,476	0.201334		50.00
51.00 05100 RECOVERY ROOM	2,364,443	13,918,163	0.169882		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	5,269,579	7,065,727	0.745794		52.00
53.00 05300 ANESTHESIOLOGY	0	0	0.000000		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	18,669,952	84,503,818	0.220936		54.00
54.01 05401 ULTRASOUND	2,389,696	20,084,746	0.118981		54.01
57.00 05700 CT SCAN	3,093,166	58,068,339	0.053268		57.00
58.00 05800 MRI	1,877,281	21,805,324	0.086093		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0.000000		59.00
60.00 06000 LABORATORY	11,571,280	133,640,903	0.086585		60.00
60.01 06001 BLOOD LABORATORY	0	0	0.000000		60.01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	2,266,985	8,509,788	0.266397		63.00
65.00 06500 RESPIRATORY THERAPY	2,769,564	19,844,596	0.139563		65.00
65.01 06501 SLEEP LAB	190,242	1,141,385	0.166676		65.01
66.00 06600 PHYSICAL THERAPY	3,463,465	8,887,094	0.389719		66.00
67.00 06700 OCCUPATIONAL THERAPY	2,472,097	9,904,727	0.249588		67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0.000000		68.00
69.00 06900 ELECTROCARDIOLOGY	2,059,186	13,983,411	0.147259		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	520,376	2,044,335	0.254545		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	14,739,952	35,191,099	0.418855		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	18,315,241	32,395,042	0.565372		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	16,555,173	48,663,031	0.340200		73.00
74.00 07400 RENAL DIALYSIS	10,770,182	36,627,877	0.294043		74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00 08800 RURAL HEALTH CLINIC	0	0	0.000000		88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000		89.00
90.00 09000 CLINIC	926,775	506,126	1.831115		90.00
90.01 09001 HOMER GLEN LAB	990,335	4,369,678	0.226638		90.01
90.02 09002 HOMER GLEN FEC	1,866,403	9,651,365	0.193382		90.02
90.03 09003 WOMEN'S HEALTH	1,937,864	4,364,232	0.444033		90.03
91.00 09100 EMERGENCY	15,716,442	63,238,866	0.248525		91.00
91.01 09101 OP MENTAL HEALTH	1,126,528	719,777	1.565107		91.01
91.02 09102 DIABETES CENTER	481,064	324,996	1.480215		91.02
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	5,450,455	5,819,037	0.936659		92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
94.00 09400 HOME PROGRAM DIALYSIS	526,853	3,220,420	0.163598		94.00
99.00 09900 CMHC	0	0	0.000000		99.00
99.10 09910 CORF	0	0	0.000000		99.10
101.00 10100 HOME HEALTH AGENCY	3,852,835	4,530,493	0.850423		101.00
<b>SPECIAL PURPOSE COST CENTERS</b>					
109.00 10900 PANCREAS ACQUISITION	0	0	0.000000		109.00
110.00 11000 INTESTINAL ACQUISITION	0	0	0.000000		110.00
111.00 11100 ISLET ACQUISITION	0	0	0.000000		111.00
200.00	Subtotal (sum of lines 50 thru 199)	176,521,991	773,662,871		200.00
201.00	Less Observation Beds	5,450,455	0		201.00
202.00	Total (Line 200 minus Line 201)	171,071,536	773,662,871		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 140213		Period: From 10/01/2011 To 09/30/2012		Worksheet D Part I Date/Time Prepared: 2/26/2013 7:45 am	
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)	PPS
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	7,451,824	0	7,451,824	54,172	137.56	30.00
31.00	03100 INTENSIVE CARE UNIT	1,295,500		1,295,500	4,336	298.78	31.00
40.00	04000 SUBPROVIDER - IPF	596,319	0	596,319	3,601	165.60	40.00
41.00	04100 SUBPROVIDER - IRF	1,066,406	0	1,066,406	5,388	197.92	41.00
42.00	04200 SUBPROVIDER	0	0	0	0	0.00	42.00
43.00	04300 NURSERY	1,542,641		1,542,641	4,970	310.39	43.00
44.00	04400 SKILLED NURSING FACILITY	0		0	0	0.00	44.00
45.00	04500 NURSING FACILITY	0		0	0	0.00	45.00
200.00	Total (lines 30-199)	11,952,690		11,952,690	72,467		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 140213	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part I Date/Time Prepared: 2/26/2013 7:45 am
		Title XVIII	Hospital	PPS

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	03000 ADULTS & PEDIATRICS	26,003	3,576,973	30.00
31.00	03100 INTENSIVE CARE UNIT	2,591	774,139	31.00
40.00	04000 SUBPROVIDER - IPF	1,268	209,981	40.00
41.00	04100 SUBPROVIDER - IRF	3,973	786,336	41.00
42.00	04200 SUBPROVIDER	0	0	42.00
43.00	04300 NURSERY	0	0	43.00
44.00	04400 SKILLED NURSING FACILITY	0	0	44.00
45.00	04500 NURSING FACILITY	0	0	45.00
200.00	Total (lines 30-199)	33,835	5,347,429	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 140213	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part II Date/Time Prepared: 2/26/2013 7:45 am
		Title XVIII	Hospital	PPS

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	4,084,389	120,638,476	0.033856	12,968,175	439,051	50.00
51.00	05100 RECOVERY ROOM	272,361	13,918,163	0.019569	1,695,050	33,170	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	625,559	7,065,727	0.088534	29,673	2,627	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	3,494,335	84,503,818	0.041351	17,803,604	736,197	54.00
54.01	05401 ULTRASOUND	369,702	20,084,746	0.018407	3,259,892	60,005	54.01
57.00	05700 CT SCAN	565,421	58,068,339	0.009737	10,877,631	105,915	57.00
58.00	05800 MRI	290,170	21,805,324	0.013307	3,316,648	44,135	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000 LABORATORY	739,384	133,640,903	0.005533	31,347,872	173,448	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	94,896	8,509,788	0.011151	3,335,796	37,197	63.00
65.00	06500 RESPIRATORY THERAPY	214,898	19,844,596	0.010829	11,083,550	120,024	65.00
65.01	06501 SLEEP LAB	21,046	1,141,385	0.018439	0	0	65.01
66.00	06600 PHYSICAL THERAPY	266,149	8,887,094	0.029948	1,957,500	58,623	66.00
67.00	06700 OCCUPATIONAL THERAPY	140,241	9,904,727	0.014159	3,578	51	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	204,147	13,983,411	0.014599	5,341,552	77,981	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	80,788	2,044,335	0.039518	397,158	15,695	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	930,975	35,191,099	0.026455	16,283,190	430,772	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	622,294	32,395,042	0.019210	8,055,643	154,749	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,099,765	48,663,031	0.022600	18,376,204	415,302	73.00
74.00	07400 RENAL DIALYSIS	718,044	36,627,877	0.019604	2,131,679	41,789	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000 CLINIC	63,746	506,126	0.125949	426	54	90.00
90.01	09001 HOMER GLEN LAB	160,699	4,369,678	0.036776	222,234	8,173	90.01
90.02	09002 HOMER GLEN FEC	102,273	9,651,365	0.010597	312,778	3,315	90.02
90.03	09003 WOMEN'S HEALTH	326,493	4,364,232	0.074811	381	29	90.03
91.00	09100 EMERGENCY	2,278,766	63,238,866	0.036034	9,158,549	330,019	91.00
91.01	09101 OP MENTAL HEALTH	201,361	719,777	0.279755	0	0	91.01
91.02	09102 DIABETES CENTER	44,149	324,996	0.135845	22,408	3,044	91.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	785,182	5,819,037	0.134933	586,389	79,123	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
94.00	09400 HOME PROGRAM DIALYSIS	27,615	3,220,420	0.008575	0	0	94.00
200.00	Total (lines 50-199)	18,824,848	769,132,378		158,567,560	3,370,488	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 140213		Period: From 10/01/2011 To 09/30/2012		Worksheet D Part III Date/Time Prepared: 2/26/2013 7:45 am	
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Hospital	PPS	
			1.00	2.00	3.00	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
						4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	49,310	0	0	49,310	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	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
200.00		Total (lines 30-199)	0	49,310	0	0	49,310	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 140213		Period: From 10/01/2011 To 09/30/2012		Worksheet D Part III Date/Time Prepared: 2/26/2013 7:45 am	
Cost Center Description		Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. Nursing School	PPS
		6.00	7.00	8.00	9.00	11.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>							
30.00	03000 ADULTS & PEDIATRICS	54,172	0.00	26,003	0	0	30.00
31.00	03100 INTENSIVE CARE UNIT	4,336	11.37	2,591	29,460	0	31.00
40.00	04000 SUBPROVIDER - I PF	3,601	0.00	1,268	0	0	40.00
41.00	04100 SUBPROVIDER - I RF	5,388	0.00	3,973	0	0	41.00
42.00	04200 SUBPROVIDER	0	0.00	0	0	0	42.00
43.00	04300 NURSERY	4,970	0.00	0	0	0	43.00
44.00	04400 SKILLED NURSING FACILITY	0	0.00	0	0	0	44.00
45.00	04500 NURSING FACILITY	0	0.00	0	0	0	45.00
200.00	Total (lines 30-199)	72,467		33,835	29,460	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 140213	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part III Date/Time Prepared: 2/26/2013 7:45 am
		Title XVIII	Hospital	PPS

Cost Center Description	PSA Adj . Allied Health Cost	PSA Adj . All Other Medical Education Cost		
	12.00	13.00		
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00 03000 ADULTS & PEDIATRICS	0	0		30.00
31.00 03100 INTENSIVE CARE UNIT	0	0		31.00
40.00 04000 SUBPROVIDER - IPF	0	0		40.00
41.00 04100 SUBPROVIDER - IRF	0	0		41.00
42.00 04200 SUBPROVIDER	0	0		42.00
43.00 04300 NURSERY	0	0		43.00
44.00 04400 SKILLED NURSING FACILITY	0	0		44.00
45.00 04500 NURSING FACILITY	0	0		45.00
200.00 Total (lines 30-199)	0	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140213	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part IV Date/Time Prepared: 2/26/2013 7:45 am
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Cost Center Description		Title XVIII				Hospital	PPS
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	54.01
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	25,727	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	66,461	0	65.00
65.01	06501	SLEEP LAB	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	23,583	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	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	0	0	975,740	0	91.00
91.01	09101	OP MENTAL HEALTH	0	0	0	0	91.01
91.02	09102	DIABETES CENTER	0	0	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	94.00
200.00		Total (lines 50-199)	0	0	1,091,511	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140213	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part IV Date/Time Prepared: 2/26/2013 7:45 am
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Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	PPS
		6.00	7.00	8.00	9.00	10.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	120,638,476	0.000000	0.000000	12,968,175	50.00
51.00	05100 RECOVERY ROOM	0	13,918,163	0.000000	0.000000	1,695,050	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	7,065,727	0.000000	0.000000	29,673	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	84,503,818	0.000000	0.000000	17,803,604	54.00
54.01	05401 ULTRASOUND	0	20,084,746	0.000000	0.000000	3,259,892	54.01
57.00	05700 CT SCAN	0	58,068,339	0.000000	0.000000	10,877,631	57.00
58.00	05800 MRI	0	21,805,324	0.000000	0.000000	3,316,648	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000 LABORATORY	25,727	133,640,903	0.000193	0.000193	31,347,872	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	8,509,788	0.000000	0.000000	3,335,796	63.00
65.00	06500 RESPIRATORY THERAPY	66,461	19,844,596	0.003349	0.003349	11,083,550	65.00
65.01	06501 SLEEP LAB	0	1,141,385	0.000000	0.000000	0	65.01
66.00	06600 PHYSICAL THERAPY	0	8,887,094	0.000000	0.000000	1,957,500	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	9,904,727	0.000000	0.000000	3,578	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	06900 ELECTROCARDIOLOGY	23,583	13,983,411	0.001686	0.001686	5,341,552	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	2,044,335	0.000000	0.000000	397,158	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	35,191,099	0.000000	0.000000	16,283,190	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	32,395,042	0.000000	0.000000	8,055,643	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	48,663,031	0.000000	0.000000	18,376,204	73.00
74.00	07400 RENAL DIALYSIS	0	36,627,877	0.000000	0.000000	2,131,679	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	09000 CLINIC	0	506,126	0.000000	0.000000	426	90.00
90.01	09001 HOMER GLEN LAB	0	4,369,678	0.000000	0.000000	222,234	90.01
90.02	09002 HOMER GLEN FEC	0	9,651,365	0.000000	0.000000	312,778	90.02
90.03	09003 WOMEN'S HEALTH	0	4,364,232	0.000000	0.000000	381	90.03
91.00	09100 EMERGENCY	975,740	63,238,866	0.015429	0.015429	9,158,549	91.00
91.01	09101 OP MENTAL HEALTH	0	719,777	0.000000	0.000000	0	91.01
91.02	09102 DIABETES CENTER	0	324,996	0.000000	0.000000	22,408	91.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	5,819,037	0.000000	0.000000	586,389	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
94.00	09400 HOME PROGRAM DIALYSIS	0	3,220,420	0.000000	0.000000	0	94.00
200.00	Total (lines 50-199)	1,091,511	769,132,378			158,567,560	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140213

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet D  
Part IV  
Date/Time Prepared:  
2/26/2013 7:45 am

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	PPS
		11.00	12.00	13.00	21.00	22.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	10,930,726	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	705,618	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	8,081	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	15,357,486	0	0	0	54.00
54.01	05401 ULTRASOUND	0	1,802,659	0	0	0	54.01
57.00	05700 CT SCAN	0	7,873,059	0	0	0	57.00
58.00	05800 MRI	0	2,533,278	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	6,050	5,397,443	1,042	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	567,361	0	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	37,119	468,772	1,570	0	0	65.00
65.01	06501 SLEEP LAB	0	175,972	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	9,006	1,425,205	2,403	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	244,939	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	8,566,916	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	4,378,473	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	4,549,563	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	2,305,084	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	209,388	0	0	0	90.00
90.01	09001 HOMER GLEN LAB	0	627,745	0	0	0	90.01
90.02	09002 HOMER GLEN FEC	0	802,114	0	0	0	90.02
90.03	09003 WOMEN'S HEALTH	0	823,248	0	0	0	90.03
91.00	09100 EMERGENCY	141,307	5,702,512	87,984	0	0	91.00
91.01	09101 OP MENTAL HEALTH	0	0	0	0	0	91.01
91.02	09102 DIABETES CENTER	0	49,070	0	0	0	91.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	1,106,893	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
200.00	Total (lines 50-199)	193,482	76,611,605	92,999	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140213	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part IV Date/Time Prepared: 2/26/2013 7:45 am
	Title XVIII	Hospital	PPS

Cost Center Description	PSA Adj . Allied Health	PSA Adj . All Other Medical Education Cost	
	23.00	24.00	
<b>ANCILLARY SERVICE COST CENTERS</b>			
50.00 05000 OPERATING ROOM	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01 05401 ULTRASOUND	0	0	54.01
57.00 05700 CT SCAN	0	0	57.00
58.00 05800 MRI	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00 06000 LABORATORY	0	0	60.00
60.01 06001 BLOOD LABORATORY	0	0	60.01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
65.00 06500 RESPIRATORY THERAPY	0	0	65.00
65.01 06501 SLEEP LAB	0	0	65.01
66.00 06600 PHYSICAL THERAPY	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>			
88.00 08800 RURAL HEALTH CLINIC	0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00 09000 CLINIC	0	0	90.00
90.01 09001 HOMER GLEN LAB	0	0	90.01
90.02 09002 HOMER GLEN FEC	0	0	90.02
90.03 09003 WOMEN'S HEALTH	0	0	90.03
91.00 09100 EMERGENCY	0	0	91.00
91.01 09101 OP MENTAL HEALTH	0	0	91.01
91.02 09102 DIABETES CENTER	0	0	91.02
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>			
94.00 09400 HOME PROGRAM DIALYSIS	0	0	94.00
200.00 Total (lines 50-199)	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 140213	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part V Date/Time Prepared: 2/26/2013 7:45 am
		Title XVIII	Hospital	PPS

Cost Center Description	Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges				
		PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	1.00	2.00	3.00	4.00		
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	0.201334	10,930,726	0	0	50.00
51.00	05100 RECOVERY ROOM	0.169882	705,618	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.745794	8,081	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.000000	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.220936	15,357,486	0	0	54.00
54.01	05401 ULTRASOUND	0.118981	1,802,659	0	0	54.01
57.00	05700 CT SCAN	0.053268	7,873,059	0	0	57.00
58.00	05800 MRI	0.086093	2,533,278	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	59.00
60.00	06000 LABORATORY	0.086585	5,397,443	0	0	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.266397	567,361	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0.139563	468,772	0	0	65.00
65.01	06501 SLEEP LAB	0.166676	175,972	0	0	65.01
66.00	06600 PHYSICAL THERAPY	0.389719	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.249588	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.147259	1,425,205	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.254545	244,939	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.418855	8,566,916	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.565372	4,378,473	84,299	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.340200	4,549,563	0	35,420	73.00
74.00	07400 RENAL DIALYSIS	0.294043	2,305,084	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800 RURAL HEALTH CLINIC	0.000000				88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000				89.00
90.00	09000 CLINIC	1.831115	209,388	0	0	90.00
90.01	09001 HOMER GLEN LAB	0.226638	627,745	0	0	90.01
90.02	09002 HOMER GLEN FEC	0.193382	802,114	0	0	90.02
90.03	09003 WOMEN'S HEALTH	0.444033	823,248	0	0	90.03
91.00	09100 EMERGENCY	0.248525	5,702,512	0	0	91.00
91.01	09101 OP MENTAL HEALTH	1.565107	0	0	0	91.01
91.02	09102 DIABETES CENTER	1.480215	49,070	0	0	91.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.936659	1,106,893	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
94.00	09400 HOME PROGRAM DIALYSIS	0.163598		0		94.00
200.00	Subtotal (see instructions)		76,611,605	84,299	35,420	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	201.00
202.00	Net Charges (line 200 +/- line 201)		76,611,605	84,299	35,420	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 140213	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part V Date/Time Prepared: 2/26/2013 7:45 am
		Title XVIII	Hospital	PPS

Cost Center Description	Costs			Hospital	PPS	
	PPS Services (see inst.)	Cost	Cost			
		Reimbursed Services Subject To Ded. & Coins. (see inst.)	Reimbursed Services Not Subject To Ded. & Coins. (see inst.)			
	5.00	6.00	7.00			
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000	OPERATING ROOM	2,200,727	0	0	50.00
51.00	05100	RECOVERY ROOM	119,872	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,027	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,393,022	0	0	54.00
54.01	05401	ULTRASOUND	214,482	0	0	54.01
57.00	05700	CT SCAN	419,382	0	0	57.00
58.00	05800	MRI	218,098	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000	LABORATORY	467,338	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	151,143	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	65,423	0	0	65.00
65.01	06501	SLEEP LAB	29,330	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	209,874	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	62,348	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,588,296	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	2,475,466	47,660	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,547,761	0	12,050	73.00
74.00	07400	RENAL DIALYSIS	677,794	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800	RURAL HEALTH CLINIC	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00	09000	CLINIC	383,414	0	0	90.00
90.01	09001	HOMER GLEN LAB	142,271	0	0	90.01
90.02	09002	HOMER GLEN FEC	155,114	0	0	90.02
90.03	09003	WOMEN'S HEALTH	365,549	0	0	90.03
91.00	09100	EMERGENCY	1,417,217	0	0	91.00
91.01	09101	OP MENTAL HEALTH	0	0	0	91.01
91.02	09102	DIABETES CENTER	72,634	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,036,781	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
94.00	09400	HOME PROGRAM DIALYSIS		0	0	94.00
200.00		Subtotal (see instructions)	19,419,363	47,660	12,050	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges		0		201.00
202.00		Net Charges (line 200 +/- line 201)	19,419,363	47,660	12,050	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 140213 Component CCN: 14S213		Period: From 10/01/2011 To 09/30/2012		Worksheet D Part II Date/Time Prepared: 2/26/2013 7:45 am	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 + col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	4,084,389	120,638,476	0.033856	9,534	323 50.00
51.00	05100	RECOVERY ROOM	272,361	13,918,163	0.019569	0	0 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	625,559	7,065,727	0.088534	0	0 52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,494,335	84,503,818	0.041351	12,661	524 54.00
54.01	05401	ULTRASOUND	369,702	20,084,746	0.018407	3,031	56 54.01
57.00	05700	CT SCAN	565,421	58,068,339	0.009737	19,854	193 57.00
58.00	05800	MRI	290,170	21,805,324	0.013307	9,360	125 58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0 59.00
60.00	06000	LABORATORY	739,384	133,640,903	0.005533	366,764	2,029 60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0 60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	94,896	8,509,788	0.011151	0	0 63.00
65.00	06500	RESPIRATORY THERAPY	214,898	19,844,596	0.010829	16,892	183 65.00
65.01	06501	SLEEP LAB	21,046	1,141,385	0.018439	0	0 65.01
66.00	06600	PHYSICAL THERAPY	266,149	8,887,094	0.029948	5,047	151 66.00
67.00	06700	OCCUPATIONAL THERAPY	140,241	9,904,727	0.014159	795	11 67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	204,147	13,983,411	0.014599	18,828	275 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	80,788	2,044,335	0.039518	2,202	87 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	930,975	35,191,099	0.026455	7,840	207 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	622,294	32,395,042	0.019210	1,988	38 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,099,765	48,663,031	0.022600	213,534	4,826 73.00
74.00	07400	RENAL DIALYSIS	718,044	36,627,877	0.019604	14,498	284 74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0 88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0 89.00
90.00	09000	CLINIC	63,746	506,126	0.125949	0	0 90.00
90.01	09001	HOMER GLEN LAB	160,699	4,369,678	0.036776	0	0 90.01
90.02	09002	HOMER GLEN FEC	102,273	9,651,365	0.010597	0	0 90.02
90.03	09003	WOMEN'S HEALTH	326,493	4,364,232	0.074811	0	0 90.03
91.00	09100	EMERGENCY	2,278,766	63,238,866	0.036034	227,566	8,200 91.00
91.01	09101	OP MENTAL HEALTH	201,361	719,777	0.279755	0	0 91.01
91.02	09102	DIABETES CENTER	44,149	324,996	0.135845	118	16 91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	5,819,037	0.000000	0	0 92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
94.00	09400	HOME PROGRAM DIALYSIS	27,615	3,220,420	0.008575	0	0 94.00
200.00		Total (lines 50-199)	18,039,666	769,132,378		930,512	17,528 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140213 Component CCN: 14S213	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part IV Date/Time Prepared: 2/26/2013 7:45 am
	Title XVIII	Subprovider - IPF	PPS

Cost Center Description		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
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	25,727	0	25,727	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	66,461	0	66,461	65.00
65.01	06501 SLEEP LAB	0	0	0	0	0	65.01
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	23,583	0	23,583	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000 CLINIC	0	0	0	0	0	90.00
90.01	09001 HOMER GLEN LAB	0	0	0	0	0	90.01
90.02	09002 HOMER GLEN FEC	0	0	0	0	0	90.02
90.03	09003 WOMEN'S HEALTH	0	0	0	0	0	90.03
91.00	09100 EMERGENCY	0	0	975,740	0	975,740	91.00
91.01	09101 OP MENTAL HEALTH	0	0	0	0	0	91.01
91.02	09102 DIABETES CENTER	0	0	0	0	0	91.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
200.00	Total (lines 50-199)	0	0	1,091,511	0	1,091,511	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140213 Component CCN: 14S213	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part IV Date/Time Prepared: 2/26/2013 7:45 am
	Title XVIII	Subprovider - IPF	PPS

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	120,638,476	0.000000	0.000000	9,534	50.00
51.00	05100 RECOVERY ROOM	0	13,918,163	0.000000	0.000000	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	7,065,727	0.000000	0.000000	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	84,503,818	0.000000	0.000000	12,661	54.00
54.01	05401 ULTRASOUND	0	20,084,746	0.000000	0.000000	3,031	54.01
57.00	05700 CT SCAN	0	58,068,339	0.000000	0.000000	19,854	57.00
58.00	05800 MRI	0	21,805,324	0.000000	0.000000	9,360	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000 LABORATORY	25,727	133,640,903	0.000193	0.000193	366,764	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	8,509,788	0.000000	0.000000	0	63.00
65.00	06500 RESPIRATORY THERAPY	66,461	19,844,596	0.003349	0.003349	16,892	65.00
65.01	06501 SLEEP LAB	0	1,141,385	0.000000	0.000000	0	65.01
66.00	06600 PHYSICAL THERAPY	0	8,887,094	0.000000	0.000000	5,047	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	9,904,727	0.000000	0.000000	795	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	06900 ELECTROCARDIOLOGY	23,583	13,983,411	0.001686	0.001686	18,828	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	2,044,335	0.000000	0.000000	2,202	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	35,191,099	0.000000	0.000000	7,840	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	32,395,042	0.000000	0.000000	1,988	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	48,663,031	0.000000	0.000000	213,534	73.00
74.00	07400 RENAL DIALYSIS	0	36,627,877	0.000000	0.000000	14,498	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	09000 CLINIC	0	506,126	0.000000	0.000000	0	90.00
90.01	09001 HOMER GLEN LAB	0	4,369,678	0.000000	0.000000	0	90.01
90.02	09002 HOMER GLEN FEC	0	9,651,365	0.000000	0.000000	0	90.02
90.03	09003 WOMEN'S HEALTH	0	4,364,232	0.000000	0.000000	0	90.03
91.00	09100 EMERGENCY	975,740	63,238,866	0.015429	0.015429	227,566	91.00
91.01	09101 OP MENTAL HEALTH	0	719,777	0.000000	0.000000	0	91.01
91.02	09102 DIABETES CENTER	0	324,996	0.000000	0.000000	118	91.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	5,819,037	0.000000	0.000000	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
94.00	09400 HOME PROGRAM DIALYSIS	0	3,220,420	0.000000	0.000000	0	94.00
200.00	Total (lines 50-199)	1,091,511	769,132,378			930,512	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140213 Component CCN: 14S213	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part IV Date/Time Prepared: 2/26/2013 7:45 am
Title XVIII		Subprovider - IPF	PPS

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
		11.00	12.00	13.00	21.00	22.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
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	71	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	57	0	0	0	0	65.00
65.01	06501 SLEEP LAB	0	0	0	0	0	65.01
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	32	0	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000 CLINIC	0	0	0	0	0	90.00
90.01	09001 HOMER GLEN LAB	0	0	0	0	0	90.01
90.02	09002 HOMER GLEN FEC	0	0	0	0	0	90.02
90.03	09003 WOMEN'S HEALTH	0	0	0	0	0	90.03
91.00	09100 EMERGENCY	3,511	0	0	0	0	91.00
91.01	09101 OP MENTAL HEALTH	0	0	0	0	0	91.01
91.02	09102 DIABETES CENTER	0	0	0	0	0	91.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
200.00	Total (lines 50-199)	3,671	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140213 Component CCN: 14S213	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part IV Date/Time Prepared: 2/26/2013 7:45 am
Title XVII I		Subprovider - IPF	PPS

Cost Center Description	PSA Adj . Allied Health	PSA Adj . All Other Medical Education Cost	
	23.00	24.00	
<b>ANCILLARY SERVICE COST CENTERS</b>			
50.00 05000 OPERATING ROOM	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01 05401 ULTRASOUND	0	0	54.01
57.00 05700 CT SCAN	0	0	57.00
58.00 05800 MRI	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00 06000 LABORATORY	0	0	60.00
60.01 06001 BLOOD LABORATORY	0	0	60.01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
65.00 06500 RESPIRATORY THERAPY	0	0	65.00
65.01 06501 SLEEP LAB	0	0	65.01
66.00 06600 PHYSICAL THERAPY	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>			
88.00 08800 RURAL HEALTH CLINIC	0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00 09000 CLINIC	0	0	90.00
90.01 09001 HOMER GLEN LAB	0	0	90.01
90.02 09002 HOMER GLEN FEC	0	0	90.02
90.03 09003 WOMEN'S HEALTH	0	0	90.03
91.00 09100 EMERGENCY	0	0	91.00
91.01 09101 OP MENTAL HEALTH	0	0	91.01
91.02 09102 DIABETES CENTER	0	0	91.02
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>			
94.00 09400 HOME PROGRAM DIALYSIS	0	0	94.00
200.00 Total (lines 50-199)	0	0	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS			Provider CCN: 140213 Component CCN: 14T213		Period: From 10/01/2011 To 09/30/2012		Worksheet D Part II Date/Time Prepared: 2/26/2013 7:45 am	
			Title XVIII		Subprovider - IRF		PPS	
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	4,084,389	120,638,476	0.033856	49,560	1,678	50.00
51.00	05100	RECOVERY ROOM	272,361	13,918,163	0.019569	2,868	56	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	625,559	7,065,727	0.088534	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,494,335	84,503,818	0.041351	116,258	4,807	54.00
54.01	05401	ULTRASOUND	369,702	20,084,746	0.018407	83,285	1,533	54.01
57.00	05700	CT SCAN	565,421	58,068,339	0.009737	113,420	1,104	57.00
58.00	05800	MRI	290,170	21,805,324	0.013307	40,172	535	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	739,384	133,640,903	0.005533	788,349	4,362	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	94,896	8,509,788	0.011151	43,629	487	63.00
65.00	06500	RESPIRATORY THERAPY	214,898	19,844,596	0.010829	485,792	5,261	65.00
65.01	06501	SLEEP LAB	21,046	1,141,385	0.018439	0	0	65.01
66.00	06600	PHYSICAL THERAPY	266,149	8,887,094	0.029948	1,719,058	51,482	66.00
67.00	06700	OCCUPATIONAL THERAPY	140,241	9,904,727	0.014159	1,452,691	20,569	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	204,147	13,983,411	0.014599	23,414	342	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	80,788	2,044,335	0.039518	7,552	298	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	930,975	35,191,099	0.026455	164,371	4,348	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	622,294	32,395,042	0.019210	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,099,765	48,663,031	0.022600	986,372	22,292	73.00
74.00	07400	RENAL DIALYSIS	718,044	36,627,877	0.019604	98,586	1,933	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	63,746	506,126	0.125949	0	0	90.00
90.01	09001	HOMER GLEN LAB	160,699	4,369,678	0.036776	0	0	90.01
90.02	09002	HOMER GLEN FEC	102,273	9,651,365	0.010597	0	0	90.02
90.03	09003	WOMEN'S HEALTH	326,493	4,364,232	0.074811	0	0	90.03
91.00	09100	EMERGENCY	2,278,766	63,238,866	0.036034	0	0	91.00
91.01	09101	OP MENTAL HEALTH	201,361	719,777	0.279755	0	0	91.01
91.02	09102	DIABETES CENTER	44,149	324,996	0.135845	1,061	144	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	5,819,037	0.000000	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
94.00	09400	HOME PROGRAM DIALYSIS	27,615	3,220,420	0.008575	0	0	94.00
200.00		Total (lines 50-199)	18,039,666	769,132,378		6,176,438	121,231	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140213 Component CCN: 14T213	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part IV Date/Time Prepared: 2/26/2013 7:45 am
	Title XVIII	Subprovider - IRF	PPS

Cost Center Description		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
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	25,727	0	25,727	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	66,461	0	66,461	65.00
65.01	06501 SLEEP LAB	0	0	0	0	0	65.01
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	23,583	0	23,583	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000 CLINIC	0	0	0	0	0	90.00
90.01	09001 HOMER GLEN LAB	0	0	0	0	0	90.01
90.02	09002 HOMER GLEN FEC	0	0	0	0	0	90.02
90.03	09003 WOMEN'S HEALTH	0	0	0	0	0	90.03
91.00	09100 EMERGENCY	0	0	975,740	0	975,740	91.00
91.01	09101 OP MENTAL HEALTH	0	0	0	0	0	91.01
91.02	09102 DIABETES CENTER	0	0	0	0	0	91.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
200.00	Total (lines 50-199)	0	0	1,091,511	0	1,091,511	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 140213 Component CCN: 14T213		Period: From 10/01/2011 To 09/30/2012		Worksheet D Part IV Date/Time Prepared: 2/26/2013 7:45 am		
				Title XVIII		Subprovider - IRF	PPS	
Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges		
		6.00	7.00	8.00	9.00	10.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	120,638,476	0.000000	0.000000	49,560	50.00
51.00	05100	RECOVERY ROOM	0	13,918,163	0.000000	0.000000	2,868	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	7,065,727	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	84,503,818	0.000000	0.000000	116,258	54.00
54.01	05401	ULTRASOUND	0	20,084,746	0.000000	0.000000	83,285	54.01
57.00	05700	CT SCAN	0	58,068,339	0.000000	0.000000	113,420	57.00
58.00	05800	MRI	0	21,805,324	0.000000	0.000000	40,172	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	25,727	133,640,903	0.000193	0.000193	788,349	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	8,509,788	0.000000	0.000000	43,629	63.00
65.00	06500	RESPIRATORY THERAPY	66,461	19,844,596	0.003349	0.003349	485,792	65.00
65.01	06501	SLEEP LAB	0	1,141,385	0.000000	0.000000	0	65.01
66.00	06600	PHYSICAL THERAPY	0	8,887,094	0.000000	0.000000	1,719,058	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	9,904,727	0.000000	0.000000	1,452,691	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	23,583	13,983,411	0.001686	0.001686	23,414	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2,044,335	0.000000	0.000000	7,552	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	35,191,099	0.000000	0.000000	164,371	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	32,395,042	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	48,663,031	0.000000	0.000000	986,372	73.00
74.00	07400	RENAL DIALYSIS	0	36,627,877	0.000000	0.000000	98,586	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	09000	CLINIC	0	506,126	0.000000	0.000000	0	90.00
90.01	09001	HOMER GLEN LAB	0	4,369,678	0.000000	0.000000	0	90.01
90.02	09002	HOMER GLEN FEC	0	9,651,365	0.000000	0.000000	0	90.02
90.03	09003	WOMEN'S HEALTH	0	4,364,232	0.000000	0.000000	0	90.03
91.00	09100	EMERGENCY	975,740	63,238,866	0.015429	0.015429	0	91.00
91.01	09101	OP MENTAL HEALTH	0	719,777	0.000000	0.000000	0	91.01
91.02	09102	DIABETES CENTER	0	324,996	0.000000	0.000000	1,061	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	5,819,037	0.000000	0.000000	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
94.00	09400	HOME PROGRAM DIALYSIS	0	3,220,420	0.000000	0.000000	0	94.00
200.00		Total (lines 50-199)	1,091,511	769,132,378			6,176,438	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140213 Component CCN: 14T213	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part IV Date/Time Prepared: 2/26/2013 7:45 am
Title XVIII		Subprovider - IRF	PPS

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
		11.00	12.00	13.00	21.00	22.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
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	152	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	1,627	0	0	0	0	65.00
65.01	06501 SLEEP LAB	0	0	0	0	0	65.01
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	39	0	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000 CLINIC	0	0	0	0	0	90.00
90.01	09001 HOMER GLEN LAB	0	0	0	0	0	90.01
90.02	09002 HOMER GLEN FEC	0	0	0	0	0	90.02
90.03	09003 WOMEN'S HEALTH	0	0	0	0	0	90.03
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
91.01	09101 OP MENTAL HEALTH	0	0	0	0	0	91.01
91.02	09102 DIABETES CENTER	0	0	0	0	0	91.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
200.00	Total (lines 50-199)	1,818	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140213 Component CCN: 14T213	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part IV Date/Time Prepared: 2/26/2013 7:45 am
Title XVII		Subprovider - IRF	PPS

Cost Center Description	PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	
	23.00	24.00	
<b>ANCILLARY SERVICE COST CENTERS</b>			
50.00 05000 OPERATING ROOM	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01 05401 ULTRASOUND	0	0	54.01
57.00 05700 CT SCAN	0	0	57.00
58.00 05800 MRI	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00 06000 LABORATORY	0	0	60.00
60.01 06001 BLOOD LABORATORY	0	0	60.01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
65.00 06500 RESPIRATORY THERAPY	0	0	65.00
65.01 06501 SLEEP LAB	0	0	65.01
66.00 06600 PHYSICAL THERAPY	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>			
88.00 08800 RURAL HEALTH CLINIC	0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00 09000 CLINIC	0	0	90.00
90.01 09001 HOMER GLEN LAB	0	0	90.01
90.02 09002 HOMER GLEN FEC	0	0	90.02
90.03 09003 WOMEN'S HEALTH	0	0	90.03
91.00 09100 EMERGENCY	0	0	91.00
91.01 09101 OP MENTAL HEALTH	0	0	91.01
91.02 09102 DIABETES CENTER	0	0	91.02
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>			
94.00 09400 HOME PROGRAM DIALYSIS	0	0	94.00
200.00 Total (lines 50-199)	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 140213	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part I Date/Time Prepared: 2/26/2013 7:45 am
		Title XIX		Hospital
				PPS

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	7,451,824	0	7,451,824	54,172	137.56	30.00
31.00	03100 INTENSIVE CARE UNIT	1,295,500		1,295,500	4,336	298.78	31.00
40.00	04000 SUBPROVIDER - IPF	596,319	0	596,319	3,601	165.60	40.00
41.00	04100 SUBPROVIDER - IRF	1,066,406	0	1,066,406	5,388	197.92	41.00
42.00	04200 SUBPROVIDER	0	0	0	0	0.00	42.00
43.00	04300 NURSERY	1,542,641		1,542,641	4,970	310.39	43.00
44.00	04400 SKILLED NURSING FACILITY	0		0	0	0.00	44.00
45.00	04500 NURSING FACILITY	0		0	0	0.00	45.00
200.00	Total (lines 30-199)	11,952,690		11,952,690	72,467		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 140213	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part I Date/Time Prepared: 2/26/2013 7:45 am
		Title XIX	Hospital	PPS

Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>				
30.00	03000 ADULTS & PEDIATRICS	7,070	972,549	30.00
31.00	03100 INTENSIVE CARE UNIT	647	193,311	31.00
40.00	04000 SUBPROVIDER - IPF	545	90,252	40.00
41.00	04100 SUBPROVIDER - IRF	76	15,042	41.00
42.00	04200 SUBPROVIDER	0	0	42.00
43.00	04300 NURSERY	742	230,309	43.00
44.00	04400 SKILLED NURSING FACILITY	0	0	44.00
45.00	04500 NURSING FACILITY	0	0	45.00
200.00	Total (lines 30-199)	9,080	1,501,463	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 140213

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet D  
Part II  
Date/Time Prepared:  
2/26/2013 7:45 am

Cost Center Description		Title XIX			Hospital	PPS	
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	4,084,389	120,638,476	0.033856	0	0	50.00
51.00	05100 RECOVERY ROOM	272,361	13,918,163	0.019569	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	625,559	7,065,727	0.088534	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	3,494,335	84,503,818	0.041351	0	0	54.00
54.01	05401 ULTRASOUND	369,702	20,084,746	0.018407	0	0	54.01
57.00	05700 CT SCAN	565,421	58,068,339	0.009737	0	0	57.00
58.00	05800 MRI	290,170	21,805,324	0.013307	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000 LABORATORY	739,384	133,640,903	0.005533	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	94,896	8,509,788	0.011151	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	214,898	19,844,596	0.010829	0	0	65.00
65.01	06501 SLEEP LAB	21,046	1,141,385	0.018439	0	0	65.01
66.00	06600 PHYSICAL THERAPY	266,149	8,887,094	0.029948	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	140,241	9,904,727	0.014159	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	204,147	13,983,411	0.014599	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	80,788	2,044,335	0.039518	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	930,975	35,191,099	0.026455	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	622,294	32,395,042	0.019210	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1,099,765	48,663,031	0.022600	0	0	73.00
74.00	07400 RENAL DIALYSIS	718,044	36,627,877	0.019604	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000 CLINIC	63,746	506,126	0.125949	0	0	90.00
90.01	09001 HOMER GLEN LAB	160,699	4,369,678	0.036776	0	0	90.01
90.02	09002 HOMER GLEN FEC	102,273	9,651,365	0.010597	0	0	90.02
90.03	09003 WOMEN'S HEALTH	326,493	4,364,232	0.074811	0	0	90.03
91.00	09100 EMERGENCY	2,278,766	63,238,866	0.036034	0	0	91.00
91.01	09101 OP MENTAL HEALTH	201,361	719,777	0.279755	0	0	91.01
91.02	09102 DIABETES CENTER	44,149	324,996	0.135845	0	0	91.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	785,182	5,819,037	0.134933	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
94.00	09400 HOME PROGRAM DIALYSIS	27,615	3,220,420	0.008575	0	0	94.00
200.00	Total (lines 50-199)	18,824,848	769,132,378		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 140213		Period: From 10/01/2011 To 09/30/2012		Worksheet D Part III Date/Time Prepared: 2/26/2013 7:45 am	
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Hospital	PPS	
			1.00	2.00	3.00	4.00	5.00	
						Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	49,310	0	0	49,310	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	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
200.00		Total (lines 30-199)	0	49,310	0	0	49,310	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140213	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part III Date/Time Prepared: 2/26/2013 7:45 am
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Cost Center Description	Title XIX				Hospital		PPS	
	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. Nursing School			
	6.00	7.00	8.00	9.00	11.00			
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>								
30.00	03000	ADULTS & PEDIATRICS	54,172	0.00	7,070	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	4,336	11.37	647	7,356	0	31.00
40.00	04000	SUBPROVIDER - I PF	3,601	0.00	545	0	0	40.00
41.00	04100	SUBPROVIDER - I RF	5,388	0.00	76	0	0	41.00
42.00	04200	SUBPROVIDER	0	0.00	0	0	0	42.00
43.00	04300	NURSERY	4,970	0.00	742	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0.00	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0.00	0	0	0	45.00
200.00		Total (lines 30-199)	72,467		9,080	7,356	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 140213	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part III Date/Time Prepared: 2/26/2013 7:45 am
		Title XIX	Hospital	PPS

Cost Center Description		PSA Adj . Allied Health Cost	PSA Adj . All Other Medical Education Cost		
		12.00	13.00		
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	31.00
40.00	04000	SUBPROVIDER - IPF	0	0	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	42.00
43.00	04300	NURSERY	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	45.00
200.00		Total (lines 30-199)	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140213	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part IV Date/Time Prepared: 2/26/2013 7:45 am
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Cost Center Description	Title XIX				Hospital	PPS	Total Cost (sum of col 1 through col 4)	
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost				
	1.00	2.00	3.00	4.00		5.00		
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00 05000 OPERATING ROOM	0	0	0	0	0	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	0	0	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	0	0	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	0	54.00
54.01 05401 ULTRASOUND	0	0	0	0	0	0	0	54.01
57.00 05700 CT SCAN	0	0	0	0	0	0	0	57.00
58.00 05800 MRI	0	0	0	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	0	0	59.00
60.00 06000 LABORATORY	0	0	25,727	0	0	0	25,727	60.00
60.01 06001 BLOOD LABORATORY	0	0	0	0	0	0	0	60.01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	0	0	63.00
65.00 06500 RESPIRATORY THERAPY	0	0	66,461	0	0	0	66,461	65.00
65.01 06501 SLEEP LAB	0	0	0	0	0	0	0	65.01
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	23,583	0	0	0	23,583	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	0	0	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	0	0	89.00
90.00 09000 CLINIC	0	0	0	0	0	0	0	90.00
90.01 09001 HOMER GLEN LAB	0	0	0	0	0	0	0	90.01
90.02 09002 HOMER GLEN FEC	0	0	0	0	0	0	0	90.02
90.03 09003 WOMEN'S HEALTH	0	0	0	0	0	0	0	90.03
91.00 09100 EMERGENCY	0	0	975,740	0	0	0	975,740	91.00
91.01 09101 OP MENTAL HEALTH	0	0	0	0	0	0	0	91.01
91.02 09102 DIABETES CENTER	0	0	0	0	0	0	0	91.02
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	0	0	94.00
200.00 Total (lines 50-199)	0	0	1,091,511	0	0	0	1,091,511	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140213

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet D  
Part IV  
Date/Time Prepared:  
2/26/2013 7:45 am

Cost Center Description			Title XIX			Hospital		PPS
			Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	0	120,638,476	0.000000	0.000000	0	50.00
51.00	05100	RECOVERY ROOM	0	13,918,163	0.000000	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	7,065,727	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	84,503,818	0.000000	0.000000	0	54.00
54.01	05401	ULTRASOUND	0	20,084,746	0.000000	0.000000	0	54.01
57.00	05700	CT SCAN	0	58,068,339	0.000000	0.000000	0	57.00
58.00	05800	MRI	0	21,805,324	0.000000	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	25,727	133,640,903	0.000193	0.000193	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	8,509,788	0.000000	0.000000	0	63.00
65.00	06500	RESPIRATORY THERAPY	66,461	19,844,596	0.003349	0.003349	0	65.00
65.01	06501	SLEEP LAB	0	1,141,385	0.000000	0.000000	0	65.01
66.00	06600	PHYSICAL THERAPY	0	8,887,094	0.000000	0.000000	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	9,904,727	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	23,583	13,983,411	0.001686	0.001686	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2,044,335	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	35,191,099	0.000000	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	32,395,042	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	48,663,031	0.000000	0.000000	0	73.00
74.00	07400	RENAL DIALYSIS	0	36,627,877	0.000000	0.000000	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	09000	CLINIC	0	506,126	0.000000	0.000000	0	90.00
90.01	09001	HOMER GLEN LAB	0	4,369,678	0.000000	0.000000	0	90.01
90.02	09002	HOMER GLEN FEC	0	9,651,365	0.000000	0.000000	0	90.02
90.03	09003	WOMEN'S HEALTH	0	4,364,232	0.000000	0.000000	0	90.03
91.00	09100	EMERGENCY	975,740	63,238,866	0.015429	0.015429	0	91.00
91.01	09101	OP MENTAL HEALTH	0	719,777	0.000000	0.000000	0	91.01
91.02	09102	DIABETES CENTER	0	324,996	0.000000	0.000000	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	5,819,037	0.000000	0.000000	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
94.00	09400	HOME PROGRAM DIALYSIS	0	3,220,420	0.000000	0.000000	0	94.00
200.00		Total (lines 50-199)	1,091,511	769,132,378			0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140213

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet D  
Part IV  
Date/Time Prepared:  
2/26/2013 7:45 am

Cost Center Description		Title XIX			Hospital	PPS	
		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
		11.00	12.00	13.00	21.00	22.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401 ULTRASOUND	0	0	0	0	0	54.01
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MRI	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
65.01	06501 SLEEP LAB	0	0	0	0	0	65.01
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000 CLINIC	0	0	0	0	0	90.00
90.01	09001 HOMER GLEN LAB	0	0	0	0	0	90.01
90.02	09002 HOMER GLEN FEC	0	0	0	0	0	90.02
90.03	09003 WOMEN'S HEALTH	0	0	0	0	0	90.03
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
91.01	09101 OP MENTAL HEALTH	0	0	0	0	0	91.01
91.02	09102 DIABETES CENTER	0	0	0	0	0	91.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
200.00	Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140213	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part IV Date/Time Prepared: 2/26/2013 7:45 am
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Cost Center Description		PSA Adj . Allied Health	PSA Adj . All Other Medical Education Cost	Title XIX	Hospital	PPS
		23.00	24.00			
<b>ANCILLARY SERVICE COST CENTERS</b>						
50.00	05000 OPERATING ROOM	0	0			50.00
51.00	05100 RECOVERY ROOM	0	0			51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0			52.00
53.00	05300 ANESTHESIOLOGY	0	0			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0			54.00
54.01	05401 ULTRASOUND	0	0			54.01
57.00	05700 CT SCAN	0	0			57.00
58.00	05800 MRI	0	0			58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0			59.00
60.00	06000 LABORATORY	0	0			60.00
60.01	06001 BLOOD LABORATORY	0	0			60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0			63.00
65.00	06500 RESPIRATORY THERAPY	0	0			65.00
65.01	06501 SLEEP LAB	0	0			65.01
66.00	06600 PHYSICAL THERAPY	0	0			66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0			67.00
68.00	06800 SPEECH PATHOLOGY	0	0			68.00
69.00	06900 ELECTROCARDIOLOGY	0	0			69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0			70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0			73.00
74.00	07400 RENAL DIALYSIS	0	0			74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>						
88.00	08800 RURAL HEALTH CLINIC	0	0			88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0			89.00
90.00	09000 CLINIC	0	0			90.00
90.01	09001 HOMER GLEN LAB	0	0			90.01
90.02	09002 HOMER GLEN FEC	0	0			90.02
90.03	09003 WOMEN'S HEALTH	0	0			90.03
91.00	09100 EMERGENCY	0	0			91.00
91.01	09101 OP MENTAL HEALTH	0	0			91.01
91.02	09102 DIABETES CENTER	0	0			91.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0			92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>						
94.00	09400 HOME PROGRAM DIALYSIS	0	0			94.00
200.00	Total (lines 50-199)	0	0			200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS			Provider CCN: 140213 Component CCN: 14S213		Period: From 10/01/2011 To 09/30/2012		Worksheet D Part II Date/Time Prepared: 2/26/2013 7:45 am	
			Title XIX		Subprovider - IPF		PPS	
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 + col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	4,084,389	120,638,476	0.033856	0	0	50.00
51.00	05100	RECOVERY ROOM	272,361	13,918,163	0.019569	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	625,559	7,065,727	0.088534	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,494,335	84,503,818	0.041351	0	0	54.00
54.01	05401	ULTRASOUND	369,702	20,084,746	0.018407	0	0	54.01
57.00	05700	CT SCAN	565,421	58,068,339	0.009737	0	0	57.00
58.00	05800	MRI	290,170	21,805,324	0.013307	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	739,384	133,640,903	0.005533	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	94,896	8,509,788	0.011151	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	214,898	19,844,596	0.010829	0	0	65.00
65.01	06501	SLEEP LAB	21,046	1,141,385	0.018439	0	0	65.01
66.00	06600	PHYSICAL THERAPY	266,149	8,887,094	0.029948	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	140,241	9,904,727	0.014159	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	204,147	13,983,411	0.014599	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	80,788	2,044,335	0.039518	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	930,975	35,191,099	0.026455	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	622,294	32,395,042	0.019210	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,099,765	48,663,031	0.022600	0	0	73.00
74.00	07400	RENAL DIALYSIS	718,044	36,627,877	0.019604	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	63,746	506,126	0.125949	0	0	90.00
90.01	09001	HOMER GLEN LAB	160,699	4,369,678	0.036776	0	0	90.01
90.02	09002	HOMER GLEN FEC	102,273	9,651,365	0.010597	0	0	90.02
90.03	09003	WOMEN'S HEALTH	326,493	4,364,232	0.074811	0	0	90.03
91.00	09100	EMERGENCY	2,278,766	63,238,866	0.036034	0	0	91.00
91.01	09101	OP MENTAL HEALTH	201,361	719,777	0.279755	0	0	91.01
91.02	09102	DIABETES CENTER	44,149	324,996	0.135845	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	5,819,037	0.000000	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
94.00	09400	HOME PROGRAM DIALYSIS	27,615	3,220,420	0.008575	0	0	94.00
200.00		Total (lines 50-199)	18,039,666	769,132,378		0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140213 Component CCN: 14S213	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part IV Date/Time Prepared: 2/26/2013 7:45 am
	Title XIX	Subprovider - IPF	PPS

Cost Center Description		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
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	25,727	0	25,727	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	66,461	0	66,461	65.00
65.01	06501 SLEEP LAB	0	0	0	0	0	65.01
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	23,583	0	23,583	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000 CLINIC	0	0	0	0	0	90.00
90.01	09001 HOMER GLEN LAB	0	0	0	0	0	90.01
90.02	09002 HOMER GLEN FEC	0	0	0	0	0	90.02
90.03	09003 WOMEN'S HEALTH	0	0	0	0	0	90.03
91.00	09100 EMERGENCY	0	0	975,740	0	975,740	91.00
91.01	09101 OP MENTAL HEALTH	0	0	0	0	0	91.01
91.02	09102 DIABETES CENTER	0	0	0	0	0	91.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
200.00	Total (lines 50-199)	0	0	1,091,511	0	1,091,511	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140213 Component CCN: 14S213	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part IV Date/Time Prepared: 2/26/2013 7:45 am
	Title XIX	Subprovider - IPF	PPS

Cost Center Description			Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	120,638,476	0.000000	0.000000		50.00
51.00	05100	RECOVERY ROOM	0	13,918,163	0.000000	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	7,065,727	0.000000	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	84,503,818	0.000000	0.000000		54.00
54.01	05401	ULTRASOUND	0	20,084,746	0.000000	0.000000		54.01
57.00	05700	CT SCAN	0	58,068,339	0.000000	0.000000		57.00
58.00	05800	MRI	0	21,805,324	0.000000	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000		59.00
60.00	06000	LABORATORY	25,727	133,640,903	0.000193	0.000193		60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	8,509,788	0.000000	0.000000		63.00
65.00	06500	RESPIRATORY THERAPY	66,461	19,844,596	0.003349	0.003349		65.00
65.01	06501	SLEEP LAB	0	1,141,385	0.000000	0.000000		65.01
66.00	06600	PHYSICAL THERAPY	0	8,887,094	0.000000	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	9,904,727	0.000000	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	23,583	13,983,411	0.001686	0.001686		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2,044,335	0.000000	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	35,191,099	0.000000	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	32,395,042	0.000000	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	48,663,031	0.000000	0.000000		73.00
74.00	07400	RENAL DIALYSIS	0	36,627,877	0.000000	0.000000		74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000		89.00
90.00	09000	CLINIC	0	506,126	0.000000	0.000000		90.00
90.01	09001	HOMER GLEN LAB	0	4,369,678	0.000000	0.000000		90.01
90.02	09002	HOMER GLEN FEC	0	9,651,365	0.000000	0.000000		90.02
90.03	09003	WOMEN'S HEALTH	0	4,364,232	0.000000	0.000000		90.03
91.00	09100	EMERGENCY	975,740	63,238,866	0.015429	0.015429		91.00
91.01	09101	OP MENTAL HEALTH	0	719,777	0.000000	0.000000		91.01
91.02	09102	DIABETES CENTER	0	324,996	0.000000	0.000000		91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	5,819,037	0.000000	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	3,220,420	0.000000	0.000000		94.00
200.00		Total (lines 50-199)	1,091,511	769,132,378				200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140213 Component CCN: 14S213	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part IV Date/Time Prepared: 2/26/2013 7:45 am
Title XIX		Subprovider - IPF	PPS

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
		11.00	12.00	13.00	21.00	22.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401 ULTRASOUND	0	0	0	0	0	54.01
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MRI	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	0	0	65.00
65.01	06501 SLEEP LAB	0	0	0	0	0	65.01
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000 CLINIC	0	0	0	0	0	90.00
90.01	09001 HOMER GLEN LAB	0	0	0	0	0	90.01
90.02	09002 HOMER GLEN FEC	0	0	0	0	0	90.02
90.03	09003 WOMEN'S HEALTH	0	0	0	0	0	90.03
91.00	09100 EMERGENCY	0	0	0	0	0	91.00
91.01	09101 OP MENTAL HEALTH	0	0	0	0	0	91.01
91.02	09102 DIABETES CENTER	0	0	0	0	0	91.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
200.00	Total (lines 50-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140213 Component CCN: 14S213	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part IV Date/Time Prepared: 2/26/2013 7:45 am
Title XIX		Subprovider - IPF	PPS

Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	
		23.00	24.00	
<b>ANCILLARY SERVICE COST CENTERS</b>				
50.00	05000 OPERATING ROOM	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01	05401 ULTRASOUND	0	0	54.01
57.00	05700 CT SCAN	0	0	57.00
58.00	05800 MRI	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000 LABORATORY	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
65.01	06501 SLEEP LAB	0	0	65.01
66.00	06600 PHYSICAL THERAPY	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>				
88.00	08800 RURAL HEALTH CLINIC	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000 CLINIC	0	0	90.00
90.01	09001 HOMER GLEN LAB	0	0	90.01
90.02	09002 HOMER GLEN FEC	0	0	90.02
90.03	09003 WOMEN'S HEALTH	0	0	90.03
91.00	09100 EMERGENCY	0	0	91.00
91.01	09101 OP MENTAL HEALTH	0	0	91.01
91.02	09102 DIABETES CENTER	0	0	91.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>				
94.00	09400 HOME PROGRAM DIALYSIS	0	0	94.00
200.00	Total (lines 50-199)	0	0	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS			Provider CCN: 140213 Component CCN: 14T213		Period: From 10/01/2011 To 09/30/2012		Worksheet D Part II Date/Time Prepared: 2/26/2013 7:45 am	
			Title XIX		Subprovider - IRF		PPS	
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>								
50.00	05000	OPERATING ROOM	4,084,389	120,638,476	0.033856	0	0	50.00
51.00	05100	RECOVERY ROOM	272,361	13,918,163	0.019569	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	625,559	7,065,727	0.088534	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,494,335	84,503,818	0.041351	0	0	54.00
54.01	05401	ULTRASOUND	369,702	20,084,746	0.018407	0	0	54.01
57.00	05700	CT SCAN	565,421	58,068,339	0.009737	0	0	57.00
58.00	05800	MRI	290,170	21,805,324	0.013307	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	739,384	133,640,903	0.005533	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	94,896	8,509,788	0.011151	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	214,898	19,844,596	0.010829	0	0	65.00
65.01	06501	SLEEP LAB	21,046	1,141,385	0.018439	0	0	65.01
66.00	06600	PHYSICAL THERAPY	266,149	8,887,094	0.029948	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	140,241	9,904,727	0.014159	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	204,147	13,983,411	0.014599	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	80,788	2,044,335	0.039518	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	930,975	35,191,099	0.026455	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	622,294	32,395,042	0.019210	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,099,765	48,663,031	0.022600	0	0	73.00
74.00	07400	RENAL DIALYSIS	718,044	36,627,877	0.019604	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	63,746	506,126	0.125949	0	0	90.00
90.01	09001	HOMER GLEN LAB	160,699	4,369,678	0.036776	0	0	90.01
90.02	09002	HOMER GLEN FEC	102,273	9,651,365	0.010597	0	0	90.02
90.03	09003	WOMEN'S HEALTH	326,493	4,364,232	0.074811	0	0	90.03
91.00	09100	EMERGENCY	2,278,766	63,238,866	0.036034	0	0	91.00
91.01	09101	OP MENTAL HEALTH	201,361	719,777	0.279755	0	0	91.01
91.02	09102	DIABETES CENTER	44,149	324,996	0.135845	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	5,819,037	0.000000	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>								
94.00	09400	HOME PROGRAM DIALYSIS	27,615	3,220,420	0.008575	0	0	94.00
200.00		Total (lines 50-199)	18,039,666	769,132,378		0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140213 Component CCN: 14T213	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part IV Date/Time Prepared: 2/26/2013 7:45 am
	Title XIX	Subprovider - IRF	PPS

Cost Center Description		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
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	25,727	0	25,727	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	66,461	0	66,461	65.00
65.01	06501 SLEEP LAB	0	0	0	0	0	65.01
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	23,583	0	23,583	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000 CLINIC	0	0	0	0	0	90.00
90.01	09001 HOMER GLEN LAB	0	0	0	0	0	90.01
90.02	09002 HOMER GLEN FEC	0	0	0	0	0	90.02
90.03	09003 WOMEN'S HEALTH	0	0	0	0	0	90.03
91.00	09100 EMERGENCY	0	0	975,740	0	975,740	91.00
91.01	09101 OP MENTAL HEALTH	0	0	0	0	0	91.01
91.02	09102 DIABETES CENTER	0	0	0	0	0	91.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
200.00	Total (lines 50-199)	0	0	1,091,511	0	1,091,511	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140213 Component CCN: 14T213	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part IV Date/Time Prepared: 2/26/2013 7:45 am
	Title XIX	Subprovider - IRF	PPS

Cost Center Description			Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
			6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	120,638,476	0.000000	0.000000		50.00
51.00	05100	RECOVERY ROOM	0	13,918,163	0.000000	0.000000		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	7,065,727	0.000000	0.000000		52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	84,503,818	0.000000	0.000000		54.00
54.01	05401	ULTRASOUND	0	20,084,746	0.000000	0.000000		54.01
57.00	05700	CT SCAN	0	58,068,339	0.000000	0.000000		57.00
58.00	05800	MRI	0	21,805,324	0.000000	0.000000		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000		59.00
60.00	06000	LABORATORY	25,727	133,640,903	0.000193	0.000193		60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	8,509,788	0.000000	0.000000		63.00
65.00	06500	RESPIRATORY THERAPY	66,461	19,844,596	0.003349	0.003349		65.00
65.01	06501	SLEEP LAB	0	1,141,385	0.000000	0.000000		65.01
66.00	06600	PHYSICAL THERAPY	0	8,887,094	0.000000	0.000000		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	9,904,727	0.000000	0.000000		67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000		68.00
69.00	06900	ELECTROCARDIOLOGY	23,583	13,983,411	0.001686	0.001686		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2,044,335	0.000000	0.000000		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	35,191,099	0.000000	0.000000		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	32,395,042	0.000000	0.000000		72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	48,663,031	0.000000	0.000000		73.00
74.00	07400	RENAL DIALYSIS	0	36,627,877	0.000000	0.000000		74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000		89.00
90.00	09000	CLINIC	0	506,126	0.000000	0.000000		90.00
90.01	09001	HOMER GLEN LAB	0	4,369,678	0.000000	0.000000		90.01
90.02	09002	HOMER GLEN FEC	0	9,651,365	0.000000	0.000000		90.02
90.03	09003	WOMEN'S HEALTH	0	4,364,232	0.000000	0.000000		90.03
91.00	09100	EMERGENCY	975,740	63,238,866	0.015429	0.015429		91.00
91.01	09101	OP MENTAL HEALTH	0	719,777	0.000000	0.000000		91.01
91.02	09102	DIABETES CENTER	0	324,996	0.000000	0.000000		91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	5,819,037	0.000000	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	3,220,420	0.000000	0.000000		94.00
200.00		Total (lines 50-199)	1,091,511	769,132,378				200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140213 Component CCN: 14T213	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part IV Date/Time Prepared: 2/26/2013 7:45 am
Title XIX		Subprovider - IRF	PPS

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
		11.00	12.00	13.00	21.00	22.00	
<b>ANCILLARY SERVICE COST CENTERS</b>							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	54.01
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
65.01	06501	SLEEP LAB	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	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	0	0	0	0	91.00
91.01	09101	OP MENTAL HEALTH	0	0	0	0	91.01
91.02	09102	DIABETES CENTER	0	0	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>							
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	94.00
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140213 Component CCN: 14T213	Period: From 10/01/2011 To 09/30/2012	Worksheet D Part IV Date/Time Prepared: 2/26/2013 7:45 am
Title XIX		Subprovider - IRF	PPS

Cost Center Description	PSA Adj . Allied Health	PSA Adj . All Other Medical Education Cost	
	23.00	24.00	
<b>ANCILLARY SERVICE COST CENTERS</b>			
50.00 05000 OPERATING ROOM	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
54.01 05401 ULTRASOUND	0	0	54.01
57.00 05700 CT SCAN	0	0	57.00
58.00 05800 MRI	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00 06000 LABORATORY	0	0	60.00
60.01 06001 BLOOD LABORATORY	0	0	60.01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
65.00 06500 RESPIRATORY THERAPY	0	0	65.00
65.01 06501 SLEEP LAB	0	0	65.01
66.00 06600 PHYSICAL THERAPY	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>			
88.00 08800 RURAL HEALTH CLINIC	0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00 09000 CLINIC	0	0	90.00
90.01 09001 HOMER GLEN LAB	0	0	90.01
90.02 09002 HOMER GLEN FEC	0	0	90.02
90.03 09003 WOMEN'S HEALTH	0	0	90.03
91.00 09100 EMERGENCY	0	0	91.00
91.01 09101 OP MENTAL HEALTH	0	0	91.01
91.02 09102 DIABETES CENTER	0	0	91.02
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>			
94.00 09400 HOME PROGRAM DIALYSIS	0	0	94.00
200.00 Total (lines 50-199)	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140213	Period: From 10/01/2011 To 09/30/2012	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 2/26/2013 7:45 am
Cost Center Description		PPS		
		1.00		
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		54,172	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		54,172	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)		48,464	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)		26,003	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		51,727,988	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)		51,727,988	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed charges)		48,990,575	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		48,990,575	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		1.055876	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)		1,010.87	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)		51,727,988	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		954.88	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		24,829,745	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)		24,829,745	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140213		Period: From 10/01/2011 To 09/30/2012		Worksheet D-1	
Title XVIII		Hospital		PPS		Date/Time Prepared: 2/26/2013 7:45 am	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
42.00 NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	9,508,768	4,336	2,192.98	2,591	5,682,011		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)					36,145,954		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					66,657,710		49.00
PASS THROUGH COST ADJUSTMENTS							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					4,380,572		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					3,563,970		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					7,944,542		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					58,713,168		53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges					0		54.00
55.00 Target amount per discharge					0.00		55.00
56.00 Target amount (line 54 x line 55)					0		56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0		57.00
58.00 Bonus payment (see instructions)					0		58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00		59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00		60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0		61.00
62.00 Relief payment (see instructions)					0		62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0		63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0		64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0		65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0		66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0		67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0		68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0		69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)					5,708		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					954.88		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					5,450,455		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140213		Period: From 10/01/2011 To 09/30/2012		Worksheet D-1 Date/Time Prepared: 2/26/2013 7:45 am	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	7,451,824	51,727,988	0.144058	5,450,455	785,182	90.00
91.00	Nursing School cost	0	51,727,988	0.000000	5,450,455	0	91.00
92.00	Allied health cost	0	51,727,988	0.000000	5,450,455	0	92.00
93.00	All other Medical Education	0	51,727,988	0.000000	5,450,455	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140213 Component CCN: 14S213	Period: From 10/01/2011 To 09/30/2012	Worksheet D-1 Date/Time Prepared: 2/26/2013 7:45 am
		Title XVIII	Subprovider - IPF	PPS
Cost Center Description				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3,601	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3,601	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)		3,601	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)		1,268	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,223,704	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)		3,223,704	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed charges)		3,669,397	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		3,669,397	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.878538	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)		1,018.99	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)		3,223,704	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		895.22	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,135,139	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,135,139	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140213		Period: From 10/01/2011 To 09/30/2012		Worksheet D-1	
		Component CCN: 14S213				Date/Time Prepared: 2/26/2013 7:45 am	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0		43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					184,742		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,319,881		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)					209,981		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					21,199		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					231,180		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					1,088,701		53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges					0		54.00
55.00 Target amount per discharge					0.00		55.00
56.00 Target amount (line 54 x line 55)					0		56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0		57.00
58.00 Bonus payment (see instructions)					0		58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00		59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00		60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0		61.00
62.00 Relief payment (see instructions)					0		62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0		63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0		64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0		65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0		66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0		67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0		68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0		69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)					0		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140213 Component CCN: 14S213		Period: From 10/01/2011 To 09/30/2012		Worksheet D-1 Date/Time Prepared: 2/26/2013 7:45 am	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	596,319	3,223,704	0.184979	0	0	90.00
91.00	Nursing School cost	0	3,223,704	0.000000	0	0	91.00
92.00	Allied health cost	0	3,223,704	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,223,704	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140213 Component CCN: 14T213	Period: From 10/01/2011 To 09/30/2012	Worksheet D-1 Date/Time Prepared: 2/26/2013 7:45 am
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			5,388 1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)			5,388 2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.			0 3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)			5,388 4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period			0 5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period			0 7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)			3,973 9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)			0 10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period			0 12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)			0 13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)			0 14.00
15.00	Total nursery days (title V or XIX only)			0 15.00
16.00	Nursery days (title V or XIX only)			0 16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period			0.00 17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period			0.00 18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period			0.00 19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period			0.00 20.00
21.00	Total general inpatient routine service cost (see instructions)			6,807,074 21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)			0 22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)			0 23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)			0 24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)			0 25.00
26.00	Total swing-bed cost (see instructions)			0 26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)			6,807,074 27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed charges)			6,163,423 28.00
29.00	Private room charges (excluding swing-bed charges)			0 29.00
30.00	Semi-private room charges (excluding swing-bed charges)			6,163,423 30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)			1.104431 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)			1,143.92 33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)			0.00 34.00
35.00	Average per diem private room cost differential (line 34 x line 31)			0.00 35.00
36.00	Private room cost differential adjustment (line 3 x line 35)			0 36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)			6,807,074 37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			1,263.38 38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			5,019,409 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)			5,019,409 41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140213		Period: From 10/01/2011 To 09/30/2012		Worksheet D-1	
		Component CCN: 14T213				Date/Time Prepared: 2/26/2013 7:45 am	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0		42.00
<b>Intensive Care Type Inpatient Hospital Units</b>							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0		43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					1,676,518		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					6,695,927		49.00
<b>PASS THROUGH COST ADJUSTMENTS</b>							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					786,336		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					123,049		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					909,385		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					5,786,542		53.00
<b>TARGET AMOUNT AND LIMIT COMPUTATION</b>							
54.00 Program discharges					0		54.00
55.00 Target amount per discharge					0.00		55.00
56.00 Target amount (line 54 x line 55)					0		56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0		57.00
58.00 Bonus payment (see instructions)					0		58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00		59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00		60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0		61.00
62.00 Relief payment (see instructions)					0		62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0		63.00
<b>PROGRAM INPATIENT ROUTINE SWING BED COST</b>							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0		64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0		65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0		66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0		67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0		68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0		69.00
<b>PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY</b>							
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
<b>PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST</b>							
87.00 Total observation bed days (see instructions)					0		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140213 Component CCN: 14T213		Period: From 10/01/2011 To 09/30/2012		Worksheet D-1 Date/Time Prepared: 2/26/2013 7:45 am	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,066,406	6,807,074	0.156661	0	0	90.00
91.00	Nursing School cost	0	6,807,074	0.000000	0	0	91.00
92.00	Allied health cost	0	6,807,074	0.000000	0	0	92.00
93.00	All other Medical Education	0	6,807,074	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140213	Period: From 10/01/2011 To 09/30/2012	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 2/26/2013 7:45 am
Cost Center Description				PPS
				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		54,172	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		54,172	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)		48,464	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)		7,070	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)		4,970	15.00
16.00	Nursery days (title V or XIX only)		742	16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		51,727,988	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)		51,727,988	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-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)		51,727,988	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		954.88	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		6,751,002	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)		6,751,002	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 140213	Period: From 10/01/2011 To 09/30/2012	Worksheet D-1 Date/Time Prepared: 2/26/2013 7:45 am		
Cost Center Description			Title XIX		Hospital	PPS	
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
42.00	NURSERY (title V & XIX only)	5,372,173	4,970	1,080.92	742	802,043	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	9,508,768	4,336	2,192.98	647	1,418,858	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)					8,971,903	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					1,403,525	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)					1,403,525	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					7,568,378	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					5,708	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					954.88	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					5,450,455	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140213		Period: From 10/01/2011 To 09/30/2012		Worksheet D-1 Date/Time Prepared: 2/26/2013 7:45 am	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	7,451,824	51,727,988	0.144058	5,450,455	785,182	90.00
91.00	Nursing School cost	0	51,727,988	0.000000	5,450,455	0	91.00
92.00	Allied health cost	0	51,727,988	0.000000	5,450,455	0	92.00
93.00	All other Medical Education	0	51,727,988	0.000000	5,450,455	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140213 Component CCN: 14S213	Period: From 10/01/2011 To 09/30/2012	Worksheet D-1 Date/Time Prepared: 2/26/2013 7:45 am
		Title XIX	Subprovider - IPF	PPS
Cost Center Description				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		3,601	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		3,601	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)		3,601	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)		545	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)		4,970	15.00
16.00	Nursery days (title V or XIX only)		742	16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		3,223,704	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)		3,223,704	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-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)		3,223,704	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		895.22	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		487,895	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)		487,895	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140213		Period: From 10/01/2011 To 09/30/2012		Worksheet D-1	
		Component CCN: 14S213				Date/Time Prepared: 2/26/2013 7:45 am	
		Title XIX		Subprovider - IPF		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0		42.00
<b>Intensive Care Type Inpatient Hospital Units</b>							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0		43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					487,895		49.00
<b>PASS THROUGH COST ADJUSTMENTS</b>							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					90,252		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)					90,252		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					397,643		53.00
<b>TARGET AMOUNT AND LIMIT COMPUTATION</b>							
54.00 Program discharges					0		54.00
55.00 Target amount per discharge					0.00		55.00
56.00 Target amount (line 54 x line 55)					0		56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0		57.00
58.00 Bonus payment (see instructions)					0		58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00		59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00		60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0		61.00
62.00 Relief payment (see instructions)					0		62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0		63.00
<b>PROGRAM INPATIENT ROUTINE SWING BED COST</b>							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0		64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0		65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0		66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0		67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0		68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0		69.00
<b>PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY</b>							
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
<b>PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST</b>							
87.00 Total observation bed days (see instructions)					0		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140213 Component CCN: 14S213		Period: From 10/01/2011 To 09/30/2012		Worksheet D-1 Date/Time Prepared: 2/26/2013 7:45 am	
		Title XIX		Subprovider - IPF		PPS	
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	596,319	3,223,704	0.184979	0	0	90.00
91.00	Nursing School cost	0	3,223,704	0.000000	0	0	91.00
92.00	Allied health cost	0	3,223,704	0.000000	0	0	92.00
93.00	All other Medical Education	0	3,223,704	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140213 Component CCN: 14T213	Period: From 10/01/2011 To 09/30/2012	Worksheet D-1 Date/Time Prepared: 2/26/2013 7:45 am
		Title XIX	Subprovider - IRF	PPS
Cost Center Description				1.00
<b>PART I - ALL PROVIDER COMPONENTS</b>				
<b>INPATIENT DAYS</b>				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		5,388	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		5,388	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		5,388	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)		76	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)		4,970	15.00
16.00	Nursery days (title V or XIX only)		742	16.00
<b>SWING BED ADJUSTMENT</b>				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		6,807,074	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		6,807,074	27.00
<b>PRIVATE ROOM DIFFERENTIAL ADJUSTMENT</b>				
28.00	General inpatient routine service charges (excluding swing-bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		6,807,074	37.00
<b>PART II - HOSPITAL AND SUBPROVIDERS ONLY</b>				
<b>PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS</b>				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,263.38	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		96,017	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)		96,017	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140213		Period: From 10/01/2011 To 09/30/2012		Worksheet D-1	
		Component CCN: 14T213				Date/Time Prepared: 2/26/2013 7:45 am	
		Title XIX		Subprovider - IRF		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	0	42.00
<b>Intensive Care Type Inpatient Hospital Units</b>							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0	0	43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
<b>Cost Center Description</b>							
					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0	0	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					96,017	0	49.00
<b>PASS THROUGH COST ADJUSTMENTS</b>							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					15,042	0	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0	0	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					15,042	0	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					80,975	0	53.00
<b>TARGET AMOUNT AND LIMIT COMPUTATION</b>							
54.00 Program discharges					0	0	54.00
55.00 Target amount per discharge					0.00	0	55.00
56.00 Target amount (line 54 x line 55)					0	0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	0	57.00
58.00 Bonus payment (see instructions)					0	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	0	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	0	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	0	61.00
62.00 Relief payment (see instructions)					0	0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0	0	63.00
<b>PROGRAM INPATIENT ROUTINE SWING BED COST</b>							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	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	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	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	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	0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	0	69.00
<b>PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY</b>							
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
<b>PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST</b>							
87.00 Total observation bed days (see instructions)					0	0	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00	0	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0	0	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140213 Component CCN: 14T213		Period: From 10/01/2011 To 09/30/2012		Worksheet D-1 Date/Time Prepared: 2/26/2013 7:45 am	
		Title XIX		Subprovider - IRF		PPS	
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,066,406	6,807,074	0.156661	0	0	90.00
91.00	Nursing School cost	0	6,807,074	0.000000	0	0	91.00
92.00	Allied health cost	0	6,807,074	0.000000	0	0	92.00
93.00	All other Medical Education	0	6,807,074	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140213	Period: From 10/01/2011 To 09/30/2012	Worksheet D-3 Date/Time Prepared: 2/26/2013 7:45 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		26,408,372	30.00
31.00	03100	INTENSIVE CARE UNIT		4,832,978	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY		0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.201354	12,968,175	50.00
51.00	05100	RECOVERY ROOM	0.169882	1,695,050	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.745794	29,673	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.220936	17,803,604	54.00
54.01	05401	ULTRASOUND	0.118981	3,259,892	54.01
57.00	05700	CT SCAN	0.053268	10,877,631	57.00
58.00	05800	MRI	0.086093	3,316,648	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.086663	31,347,872	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.266397	3,335,796	63.00
65.00	06500	RESPIRATORY THERAPY	0.140016	11,083,550	65.00
65.01	06501	SLEEP LAB	0.166676	0	65.01
66.00	06600	PHYSICAL THERAPY	0.389719	1,957,500	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.249588	3,578	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.147259	5,341,552	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.254545	397,158	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.418855	16,283,190	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.565372	8,055,643	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.340200	18,376,204	73.00
74.00	07400	RENAL DIALYSIS	0.295334	2,131,679	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	89.00
90.00	09000	CLINIC	1.831115	426	90.00
90.01	09001	HOMER GLEN LAB	0.226638	222,234	90.01
90.02	09002	HOMER GLEN FEC	0.193382	312,778	90.02
90.03	09003	WOMEN'S HEALTH	0.444033	381	90.03
91.00	09100	EMERGENCY	0.248905	9,158,549	91.00
91.01	09101	OP MENTAL HEALTH	1.565107	0	91.01
91.02	09102	DIABETES CENTER	1.480409	22,408	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.936659	586,389	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
94.00	09400	HOME PROGRAM DIALYSIS	0.163598	0	94.00
200.00		Total (sum of lines 50-94 and 96-98)		158,567,560	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)		158,567,560	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140213	Period: From 10/01/2011 To 09/30/2012	Worksheet D-3	
		Component CCN: 14S213		Date/Time Prepared: 2/26/2013 7:45 am	
		Title XVIII	Subprovider - IPF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
40.00	04000	SUBPROVIDER - IPF		1,293,967	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY		0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.201354	9,534	50.00
51.00	05100	RECOVERY ROOM	0.169882	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.745794	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.220936	12,661	54.00
54.01	05401	ULTRASOUND	0.118981	3,031	54.01
57.00	05700	CT SCAN	0.053268	19,854	57.00
58.00	05800	MRI	0.086093	9,360	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.086663	366,764	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.266397	0	63.00
65.00	06500	RESPIRATORY THERAPY	0.140016	16,892	65.00
65.01	06501	SLEEP LAB	0.166676	0	65.01
66.00	06600	PHYSICAL THERAPY	0.389719	5,047	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.249588	795	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.147259	18,828	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.254545	2,202	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.418855	7,840	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.565372	1,988	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.340200	213,534	73.00
74.00	07400	RENAL DIALYSIS	0.295334	14,498	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	89.00
90.00	09000	CLINIC	1.831115	0	90.00
90.01	09001	HOMER GLEN LAB	0.226638	0	90.01
90.02	09002	HOMER GLEN FEC	0.193382	0	90.02
90.03	09003	WOMEN'S HEALTH	0.444033	0	90.03
91.00	09100	EMERGENCY	0.248905	227,566	91.00
91.01	09101	OP MENTAL HEALTH	1.565107	0	91.01
91.02	09102	DIABETES CENTER	1.480409	118	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.936659	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
94.00	09400	HOME PROGRAM DIALYSIS	0.163598	0	94.00
200.00		Total (sum of lines 50-94 and 96-98)		930,512	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)		930,512	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140213	Period: From 10/01/2011 To 09/30/2012	Worksheet D-3	
		Component CCN: 14T213		Date/Time Prepared: 2/26/2013 7:45 am	
		Title XVIII	Subprovider - IRF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
<b>INPATIENT ROUTINE SERVICE COST CENTERS</b>					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		3,665,710	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY		0	43.00
<b>ANCILLARY SERVICE COST CENTERS</b>					
50.00	05000	OPERATING ROOM	0.201354	49,560	50.00
51.00	05100	RECOVERY ROOM	0.169882	2,868	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.745794	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.220936	116,258	54.00
54.01	05401	ULTRASOUND	0.118981	83,285	54.01
57.00	05700	CT SCAN	0.053268	113,420	57.00
58.00	05800	MRI	0.086093	40,172	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.086663	788,349	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.266397	43,629	63.00
65.00	06500	RESPIRATORY THERAPY	0.140016	485,792	65.00
65.01	06501	SLEEP LAB	0.166676	0	65.01
66.00	06600	PHYSICAL THERAPY	0.389719	1,719,058	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.249588	1,452,691	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.147259	23,414	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.254545	7,552	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.418855	164,371	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.565372	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.340200	986,372	73.00
74.00	07400	RENAL DIALYSIS	0.295334	98,586	74.00
<b>OUTPATIENT SERVICE COST CENTERS</b>					
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	89.00
90.00	09000	CLINIC	1.831115	0	90.00
90.01	09001	HOMER GLEN LAB	0.226638	0	90.01
90.02	09002	HOMER GLEN FEC	0.193382	0	90.02
90.03	09003	WOMEN'S HEALTH	0.444033	0	90.03
91.00	09100	EMERGENCY	0.248905	0	91.00
91.01	09101	OP MENTAL HEALTH	1.565107	0	91.01
91.02	09102	DIABETES CENTER	1.480409	1,061	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.936659	0	92.00
<b>OTHER REIMBURSABLE COST CENTERS</b>					
94.00	09400	HOME PROGRAM DIALYSIS	0.163598	0	94.00
200.00		Total (sum of lines 50-94 and 96-98)		6,176,438	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)		6,176,438	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140213	Period: From 10/01/2011 To 09/30/2012	Worksheet E Part A Date/Time Prepared: 2/26/2013 7:45 am
		Title XVIII	Hospital	PPS
			before 1/1	on/after 1/1
			1.00	1.01
<b>PART A - INPATIENT HOSPITAL SERVICES UNDER PPS</b>				
1.00	DRG Amounts Other than Outlier Payments		46,955,331	1.00
2.00	Outlier payments for discharges. (see instructions)		652,831	2.00
2.01	Outlier reconciliation amount		0	2.01
3.00	Managed Care Simulated Payments		1,395,413	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		238.30	4.00
<b>Indirect Medical Education Adjustment</b>				
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 Federal Register, page 50069, August 1, 2002.		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		0.00	12.00
13.00	Total allowable FTE count for the prior year.		0.00	13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00	14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00	15.00
16.00	Adjustment for residents in initial years of the program		0.00	16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00	17.00
18.00	Adjusted rolling average FTE count		0.00	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000	21.00
22.00	IME payment adjustment (see instructions)		0	22.00
<b>Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA</b>				
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00	23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment. (see instructions)		0.000000	27.00
28.00	IME Adjustment (see instructions)		0	28.00
29.00	Total IME payment (sum of lines 22 and 28)		0	29.00
<b>Disproportionate Share Adjustment</b>				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		4.22	30.00
31.00	Percentage of Medicaid patient days to total days reported on Worksheet S-2, Part I, line 24. (see instructions)		14.93	31.00
32.00	Sum of lines 30 and 31		19.15	32.00
33.00	Allowable disproportionate share percentage (see instructions)		5.20	33.00
34.00	Disproportionate share adjustment (see instructions)		2,441,677	34.00
<b>Additional payment for high percentage of ESRD beneficiary discharges</b>				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0	40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	41.00
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00	42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000	44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41)		0	46.00
47.00	Subtotal (see instructions)		50,049,839	47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0	48.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140213	Period: From 10/01/2011 To 09/30/2012	Worksheet E Part A Date/Time Prepared: 2/26/2013 7:45 am
		Title XVIII	Hospital	PPS
		before 1/1	on/after 1/1	
		1.00	1.01	
49.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)	50,049,839		49.00
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)	4,083,762		50.00
51.00	Exception payment for inpatient program capital (Worksheet L, Part III, see instructions)	0		51.00
52.00	Direct graduate medical education payment (from Worksheet E-4, line 49 see instructions).	0		52.00
53.00	Nursing and Allied Health Managed Care payment	2,936		53.00
54.00	Special add-on payments for new technologies	0		54.00
55.00	Net organ acquisition cost (Worksheet D-4 Part III, col. 1, line 69)	0		55.00
56.00	Cost of teaching physicians (Worksheet D-5, Part II, col. 3, line 20)	0		56.00
57.00	Routine service other pass through costs (from Wkst D, Part III, column 9, lines 30-35).	29,460		57.00
58.00	Ancillary service other pass through costs Worksheet D, Part IV, col. 11 line 200)	193,482		58.00
59.00	Total (sum of amounts on lines 49 through 58)	54,359,479		59.00
60.00	Primary payer payments	37,716		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)	54,321,763		61.00
62.00	Deductibles billed to program beneficiaries	5,125,388		62.00
63.00	Coinsurance billed to program beneficiaries	226,881		63.00
64.00	Allowable bad debts (see instructions)	844,687		64.00
65.00	Adjusted reimbursable bad debts (see instructions)	591,281		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)	641,498		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	49,560,775		67.00
68.00	Credits received from manufacturers for replaced devices applicable to MS-DRG (see instructions)	0		68.00
69.00	Outlier payments reconciliation (Sum of lines 93, 95 and 96). (For SCH see instructions)	0		69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0		70.00
70.95	Recovery of Accelerated Depreciation	0		70.95
70.96	Low Volume Payment-1	0		70.96
70.97	Low Volume Payment-2	0		70.97
70.98	Low Volume Payment-3	0		70.98
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)	49,560,775		71.00
72.00	Interim payments	50,165,697		72.00
73.00	Tentative settlement (for contractor use only)	0		73.00
74.00	Balance due provider (Program) (line 71 minus the sum of lines 72 and 73)	-604,922		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2	0		75.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
90.00	Operating outlier amount from Worksheet E, Part A line 2 (see instructions)	0		90.00
91.00	Capital outlier from Worksheet L, Part I, line 2	0		91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)	0		92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)	0		93.00
94.00	The rate used to calculate the Time Value of Money	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

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140213	Period: From 10/01/2011 To 09/30/2012	Worksheet E Part B Date/Time Prepared: 2/26/2013 7:45 am
		Title XVIII	Hospital	PPS
		1.00		
<b>PART B - MEDICAL AND OTHER HEALTH SERVICES</b>				
1.00	Medical and other services (see instructions)		59,710	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		19,326,364	2.00
3.00	PPS payments		15,960,538	3.00
4.00	Outlier payment (see instructions)		46,019	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200		92,999	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		59,710	11.00
<b>COMPUTATION OF LESSER OF COST OR CHARGES</b>				
<b>Reasonable charges</b>				
12.00	Ancillary service charges		119,719	12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		119,719	14.00
<b>Customary charges</b>				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		119,719	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		60,009	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)		59,710	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)		16,099,556	24.00
<b>COMPUTATION OF REIMBURSEMENT SETTLEMENT</b>				
25.00	Deductibles and coinsurance (for CAH, see instructions)		16,860	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		3,582,331	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)		12,560,075	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		12,560,075	30.00
31.00	Primary payer payments		854	31.00
32.00	Subtotal (line 30 minus line 31)		12,559,221	32.00
<b>ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)</b>				
33.00	Composite rate ESRD (from Worksheet I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		552,708	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		386,896	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		444,853	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)		12,946,117	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)		12,946,117	40.00
41.00	Interim payments		12,889,551	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (line 40 minus the sum of lines 41, and 42)		56,566	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		0	44.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 140213	Period: From 10/01/2011 To 09/30/2012	Worksheet E Part B Date/Time Prepared: 2/26/2013 7:45 am
	Title XVIII	Hospital	PPS
WORKSHEET OVERRIDE VALUES			Overrides
			1.00
112.00 Override of Ancillary service charges (line 12)	0	112.00	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140213

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet E-1  
Part I  
Date/Time Prepared:  
2/26/2013 7:45 am

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		50,094,707		12,890,243	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	05/04/2012	29,983		0	3.01	
3.02		09/17/2012	41,007	09/17/2012	3,648	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	05/04/2012	4,340	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)		70,990		-692	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)		50,165,697		12,889,551	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		56,566	6.01	
6.02	SETTLEMENT TO PROGRAM		604,922		0	6.02	
7.00	Total Medicare program liability (see instructions)		49,560,775		12,946,117	7.00	
				Contractor Number	Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140213  
Component CCN: 14S213

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet E-1  
Part I  
Date/Time Prepared:  
2/26/2013 7:45 am  
PPS

Title XVIII

Subprovider -  
IPF

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		905,254		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)		905,254		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		65,417		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		970,671		0	7.00
				Contractor Number	Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140213  
Component CCN: 14T213

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet E-1  
Part I  
Date/Time Prepared:  
2/26/2013 7:45 am  
PPS

Title XVIII

Subprovider -  
IRF

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider					1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		5,619,647		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	05/04/2012	25,057		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)		25,057		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)		5,644,704		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		5,803		0	6.02
7.00	Total Medicare program liability (see instructions)		5,638,901		0	7.00
				Contractor Number	Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140213 Component CCN: 14S213	Period: From 10/01/2011 To 09/30/2012	Worksheet E-3 Part II Date/Time Prepared: 2/26/2013 7:45 am
		Title XVIIII	Subprovider - IPF	PPS
				1.00
<b>PART II - MEDICARE PART A SERVICES - IPF PPS</b>				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)			1,027,641 1.00
2.00	Net IPF PPS Outlier Payments			4,992 2.00
3.00	Net IPF PPS ECT Payments			0 3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)			0.00 4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 4.01
5.00	New Teaching program adjustment. (see instructions)			0.00 5.00
6.00	Current year's unweighted FTE count of I&R other than FTEs in the first 3 years of a "new teaching program". (see inst.)			0.00 6.00
7.00	Current year's unweighted I&R FTE count for residents within the first 3 years of a "new teaching program". (see inst.)			0.00 7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)			0.00 8.00
9.00	Average Daily Census (see instructions)			9,838,798 9.00
10.00	Medical Education Adjustment Factor $\{(1 + (\text{line 8}/\text{line 9})) \text{ raised to the power of } .5150 - 1\}$ .			0.000000 10.00
11.00	Medical Education 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)			1,032,633 12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)			0 13.00
14.00	Organ acquisition			0 14.00
15.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)			0 15.00
16.00	Subtotal (see instructions)			1,032,633 16.00
17.00	Primary payer payments			0 17.00
18.00	Subtotal (line 16 less line 17).			1,032,633 18.00
19.00	Deductibles			117,264 19.00
20.00	Subtotal (line 18 minus line 19)			915,369 20.00
21.00	Coinsurance			10,115 21.00
22.00	Subtotal (line 20 minus line 21)			905,254 22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			88,208 23.00
24.00	Adjusted reimbursable bad debts (see instructions)			61,746 24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			69,168 25.00
26.00	Subtotal (sum of lines 22 and 24)			967,000 26.00
27.00	Direct graduate medical education payments (from Worksheet E-4, line 49)			0 27.00
28.00	Other pass through costs (see instructions)			3,671 28.00
29.00	Outlier payments reconciliation			0 29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 30.00
30.99	Recovery of Accelerated Depreciation			0 30.99
31.00	Total amount payable to the provider (see instructions)			970,671 31.00
32.00	Interim payments			905,254 32.00
33.00	Tentative settlement (for contractor use only)			0 33.00
34.00	Balance due provider/program (line 31 minus the sum lines 32 and 33)			65,417 34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2			0 35.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2			4,992 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140213	Period: From 10/01/2011 To 09/30/2012	Worksheet E-3 Part III Date/Time Prepared: 2/26/2013 7:45 am
		Component CCN: 14T213	Title XVIIII	Subprovider - IRF
		PPS		
		1.00		
<b>PART III - MEDICARE PART A SERVICES - IRF PPS</b>				
1.00	Net Federal PPS Payment (see instructions)		5,203,335	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)		0.0178	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)		75,932	3.00
4.00	Outlier Payments		410,542	4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)		0.00	5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)		0.00	5.01
6.00	New Teaching program adjustment. (see instructions)		0.00	6.00
7.00	Current year's unweighted FTE count of I&R other than FTEs in the first 3 years of a "new teaching program". (see inst.)		0.00	7.00
8.00	Current year's unweighted I&R FTE count for residents within the first 3 years of a "new teaching program". (see inst.)		0.00	8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)		0.00	9.00
10.00	Average Daily Census (see instructions)		14.721311	10.00
11.00	Medical Education Adjustment Factor $\{((1 + (\text{line } 9/\text{line } 10)) \text{ raised to the power of } .6876 - 1)\}$ .		0.000000	11.00
12.00	Medical Education Adjustment (line 1 multiplied by line 11).		0	12.00
13.00	Total PPS Payment (sum of lines 1, 3, 4 and 12)		5,689,809	13.00
14.00	Nursing and Allied Health Managed Care payment (see instruction)		0	14.00
15.00	Organ acquisition		0	15.00
16.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)		0	16.00
17.00	Subtotal (see instructions)		5,689,809	17.00
18.00	Primary payer payments		3,263	18.00
19.00	Subtotal (line 17 less line 18).		5,686,546	19.00
20.00	Deductibles		23,024	20.00
21.00	Subtotal (line 19 minus line 20)		5,663,522	21.00
22.00	Coinsurance		30,430	22.00
23.00	Subtotal (line 21 minus line 22)		5,633,092	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		5,701	24.00
25.00	Adjusted reimbursable bad debts (see instructions)		3,991	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		5,701	26.00
27.00	Subtotal (sum of lines 23 and 25)		5,637,083	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 49)		0	28.00
29.00	Other pass through costs (see instructions)		1,818	29.00
30.00	Outlier payments reconciliation		0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	31.00
31.99	Recovery of Accelerated Depreciation		0	31.99
32.00	Total amount payable to the provider (see instructions)		5,638,901	32.00
33.00	Interim payments		5,644,704	33.00
34.00	Tentative settlement (for contractor use only)		0	34.00
35.00	Balance due provider/program (line 32 minus the sum lines 33 and 34)		-5,803	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		0	36.00
<b>TO BE COMPLETED BY CONTRACTOR</b>				
50.00	Original outlier amount from Worksheet E-3, Part III, line 4		410,542	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)		0	51.00
52.00	The rate used to calculate the Time Value of Money		0.00	52.00
53.00	Time Value of Money (see instructions)		0	53.00

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

Provider CCN: 140213

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet G

Date/Time Prepared:  
2/26/2013 7:45 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
<b>CURRENT ASSETS</b>						
1.00	Cash on hand in banks	22,189,204	0	0	0	1.00
2.00	Temporary investments	5,634,416	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	34,057,861	0	0	0	4.00
5.00	Other receivable	42,621,958	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	205,552	0	0	0	7.00
8.00	Prepaid expenses	2,375,394	0	0	0	8.00
9.00	Other current assets	75	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	107,084,460	0	0	0	11.00
<b>FIXED ASSETS</b>						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	537,618,451	0	0	0	15.00
16.00	Accumulated depreciation	-85,439,923	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)	452,178,528	0	0	0	30.00
<b>OTHER ASSETS</b>						
31.00	Investments	109,790,114	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	31,060,015	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	140,850,129	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	700,113,117	0	0	0	36.00
<b>CURRENT LIABILITIES</b>						
37.00	Accounts payable	8,054,843	0	0	0	37.00
38.00	Salaries, wages, and fees payable	14,048,240	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	5,150,000	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	29,263,958	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	56,517,041	0	0	0	45.00
<b>LONG TERM LIABILITIES</b>						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	392,352,106	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	891,105	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	393,243,211	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	449,760,252	0	0	0	51.00
<b>CAPITAL ACCOUNTS</b>						
52.00	General fund balance	250,352,865	0	0	0	52.00
53.00	Specific purpose fund	0	0	0	0	53.00
54.00	Donor created - endowment fund balance - restricted	0	0	0	0	54.00
55.00	Donor created - endowment fund balance - unrestricted	0	0	0	0	55.00
56.00	Governing body created - endowment fund balance	0	0	0	0	56.00
57.00	Plant fund balance - invested in plant	0	0	0	0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion	0	0	0	0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	250,352,865	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	700,113,117	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 140213

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet G-1

Date/Time Prepared:  
2/26/2013 7:45 am

		General Fund		Special Purpose Fund		
		1.00	2.00	3.00	4.00	
1.00	Fund balances at beginning of period		228,475,150		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		18,650,219			2.00
3.00	Total (sum of line 1 and line 2)		247,125,369		0	3.00
4.00	Additions (credit adjustments) (specify)	0		0		4.00
5.00	CONTRIBUTIONS FOR SPECIFIC PURPOSES	2,371,784		0		5.00
6.00	DECREASE IN TEMPORARILY RESTRICTED N	364,090		0		6.00
7.00	DECREASE IN PERMANENTLY RESTRICTED N	491,622		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		3,227,496		0	10.00
11.00	Subtotal (line 3 plus line 10)		250,352,865		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		250,352,865		0	19.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 140213

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet G-1

Date/Time Prepared:  
2/26/2013 7:45 am

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 140213

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet G-2  
Parts I & II  
Date/Time Prepared:  
2/26/2013 7:45 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
<b>PART I - PATIENT REVENUES</b>					
General Inpatient Routine Services					
1.00	Hospital	48,990,575		48,990,575	1.00
2.00	SUBPROVIDER - IPF	3,669,397		3,669,397	2.00
3.00	SUBPROVIDER - IRF	6,163,423		6,163,423	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)	58,823,395		58,823,395	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	9,205,354		9,205,354	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)	9,205,354		9,205,354	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	68,028,749		68,028,749	17.00
18.00	Ancillary services	306,401,121	376,455,956	682,857,077	18.00
19.00	Outpatient services	18,694,748	73,519,750	92,214,498	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		4,530,493	4,530,493	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC		0	0	24.00
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	393,124,618	454,506,199	847,630,817	28.00
<b>PART II - OPERATING EXPENSES</b>					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		278,428,276		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)		278,428,276		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 140213

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet G-3

Date/Time Prepared:  
2/26/2013 7:45 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	847,630,817	1.00
2.00	Less contractual allowances and discounts on patients' accounts	582,073,204	2.00
3.00	Net patient revenues (line 1 minus line 2)	265,557,613	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	278,428,276	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-12,870,663	5.00
<b>OTHER INCOME</b>			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and telegraph service	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	4,024,467	24.00
24.01	NON-OPERATING INCOME	27,496,418	24.01
24.02		0	24.02
25.00	Total other income (sum of lines 6-24)	31,520,885	25.00
26.00	Total (line 5 plus line 25)	18,650,222	26.00
27.00		0	27.00
27.01	ROUNDING	3	27.01
28.00	Total other expenses (sum of line 27 and subscripts)	3	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	18,650,219	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 140213

Period:

Worksheet H

HHA CCN: 147452

From 10/01/2011  
To 09/30/2012

Date/Time Prepared:  
2/26/2013 7:45 am

Home Health  
Agency I

PPS

	Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs		
	1.00	2.00	3.00	4.00	5.00		
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	Capital Related - Bldg. & Fixtures		0		0	1.00	
2.00	Capital Related - Movable Equipment		0		0	2.00	
3.00	Plant Operation & Maintenance	0	0	0	0	3.00	
4.00	Transportation	0	0	0	0	4.00	
5.00	Administrative and General	413,130	0	15	935	73,600	5.00
<b>HHA REIMBURSABLE SERVICES</b>							
6.00	Skilled Nursing Care	959,512	0	62,895	0	42,877	6.00
7.00	Physical Therapy	0	0	0	682,859	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	4,193	0	28	0	0	10.00
11.00	Home Health Aide	49,970	0	8,309	0	249	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
<b>HHA NONREIMBURSABLE SERVICES</b>							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	1,426,805	0	71,247	683,794	116,726	24.00

Column, 6 line 24 should agree with the Worksheet A, column 7, line 101, or subscript as applicable.

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 140213

Period: From 10/01/2011

Worksheet H

HHA CCN: 147452

To 09/30/2012

Date/Time Prepared: 2/26/2013 7:45 am

Home Health Agency I

PPS

	Total (sum of col. 1 thru 5)	Reclassification	Reclassified Trial Balance (col. 6 + col. 7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)	
	6.00	7.00	8.00	9.00	10.00	
<b>GENERAL SERVICE COST CENTERS</b>						
1.00 Capital Related - Bldg. & Fixtures	0	0	0	0	0	1.00
2.00 Capital Related - Movable Equipment	0	0	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	487,680	34,992	522,672	-8,087	514,585	5.00
<b>HHA REIMBURSABLE SERVICES</b>						
6.00 Skilled Nursing Care	1,065,284	0	1,065,284	0	1,065,284	6.00
7.00 Physical Therapy	682,859	-12,112	670,747	0	670,747	7.00
8.00 Occupational Therapy	0	0	0	0	0	8.00
9.00 Speech Pathology	0	0	0	0	0	9.00
10.00 Medical Social Services	4,221	0	4,221	0	4,221	10.00
11.00 Home Health Aide	58,528	0	58,528	0	58,528	11.00
12.00 Supplies (see instructions)	0	0	0	0	0	12.00
13.00 Drugs	0	0	0	0	0	13.00
14.00 DME	0	0	0	0	0	14.00
<b>HHA NONREIMBURSABLE SERVICES</b>						
15.00 Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00 Respiratory Therapy	0	0	0	0	0	16.00
17.00 Private Duty Nursing	0	0	0	0	0	17.00
18.00 Clinic	0	0	0	0	0	18.00
19.00 Health Promotion Activities	0	0	0	0	0	19.00
20.00 Day Care Program	0	0	0	0	0	20.00
21.00 Home Delivered Meals Program	0	0	0	0	0	21.00
22.00 Homemaker Service	0	0	0	0	0	22.00
23.00 All Others (specify)	0	0	0	0	0	23.00
24.00 Total (sum of lines 1-23)	2,298,572	22,880	2,321,452	-8,087	2,313,365	24.00

Column, 6 line 24 should agree with the Worksheet A, column 7, line 101, or subscript as applicable.

COST ALLOCATION - HHA GENERAL SERVICE COST		Provider CCN: 140213	Period: From 10/01/2011	Worksheet H-1
		HHA CCN: 147452	To 09/30/2012	Part I
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	Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	
		Bldgs & Fixtures	Movable Equipment			
		1.00	2.00			
<b>GENERAL SERVICE COST CENTERS</b>						
1.00	Capital Related - Bldg. & Fixtures	0	0			1.00
2.00	Capital Related - Movable Equipment	0	0	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	514,585	0	0	0	5.00
<b>HHA REIMBURSABLE SERVICES</b>						
6.00	Skilled Nursing Care	1,065,284	0	0	0	6.00
7.00	Physical Therapy	670,747	0	0	0	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	4,221	0	0	0	10.00
11.00	Home Health Aide	58,528	0	0	0	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
<b>HHA NONREIMBURSABLE SERVICES</b>						
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
24.00	Total (sum of lines 1-23)	2,313,365	0	0	0	24.00

COST ALLOCATION - HHA GENERAL SERVICE COST		Provider CCN: 140213	Period:	Worksheet H-1
		HHA CCN: 147452	From 10/01/2011	Part I
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	Subtotal (col s. 0-4)	Administrative & General	Total (col s. 4A + 5)	
	4A.00	5.00	6.00	
<b>GENERAL SERVICE COST CENTERS</b>				
1.00	Capital Related - Bldg. & Fixtures	0		1.00
2.00	Capital Related - Movable Equipment	0		2.00
3.00	Plant Operation & Maintenance	0		3.00
4.00	Transportation			4.00
5.00	Administrative and General	514,585	514,585	5.00
<b>HHA REIMBURSABLE SERVICES</b>				
6.00	Skilled Nursing Care	1,065,284	304,751	1,370,035
7.00	Physical Therapy	670,747	191,883	862,630
8.00	Occupational Therapy	0	0	0
9.00	Speech Pathology	0	0	0
10.00	Medical Social Services	4,221	1,208	5,429
11.00	Home Health Aide	58,528	16,743	75,271
12.00	Supplies (see instructions)	0	0	0
13.00	Drugs	0	0	0
14.00	DME	0	0	0
<b>HHA NONREIMBURSABLE SERVICES</b>				
15.00	Home Dialysis Aide Services	0	0	0
16.00	Respiratory Therapy	0	0	0
17.00	Private Duty Nursing	0	0	0
18.00	Clinic	0	0	0
19.00	Health Promotion Activities	0	0	0
20.00	Day Care Program	0	0	0
21.00	Home Delivered Meals Program	0	0	0
22.00	Homemaker Service	0	0	0
23.00	All Others (specify)	0	0	0
24.00	Total (sum of lines 1-23)	2,313,365		2,313,365

COST ALLOCATION - HHA STATISTICAL BASIS	Provider CCN: 140213	Period:	Worksheet H-1
	HHA CCN: 147452	From 10/01/2011 To 09/30/2012	Part II Date/Time Prepared: 2/26/2013 7:45 am
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	Capital Related Costs				Transportation (MILEAGE)	Reconciliation	
	Bldgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)				
	1.00	2.00	3.00	4.00			
<b>GENERAL SERVICE COST CENTERS</b>							
1.00	Capital Related - Bldg. & Fixtures	0				0	1.00
2.00	Capital Related - Movable Equipment		0			0	2.00
3.00	Plant Operation & Maintenance	0	0	0		0	3.00
4.00	Transportation (see instructions)	0	0	0	0	0	4.00
5.00	Administrative and General	0	0	0	0	-514,585	5.00
<b>HHA REIMBURSABLE SERVICES</b>							
6.00	Skilled Nursing Care	0	0	0	0	0	6.00
7.00	Physical Therapy	0	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	0	0	0	0	0	10.00
11.00	Home Health Aide	0	0	0	0	0	11.00
12.00	Supplies (see instructions)	0	0	0	0	0	12.00
13.00	Drugs	0	0	0	0	0	13.00
14.00	DME	0	0	0	0	0	14.00
<b>HHA NONREIMBURSABLE SERVICES</b>							
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00
16.00	Respiratory Therapy	0	0	0	0	0	16.00
17.00	Private Duty Nursing	0	0	0	0	0	17.00
18.00	Clinic	0	0	0	0	0	18.00
19.00	Health Promotion Activities	0	0	0	0	0	19.00
20.00	Day Care Program	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	22.00
23.00	All Others (specify)	0	0	0	0	0	23.00
24.00	Total (sum of lines 1-23)	0	0	0	0	-514,585	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0	0	25.00
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		26.00

COST ALLOCATION - HHA STATISTICAL BASIS	Provider CCN: 140213	Period:	Worksheet H-1
	HHA CCN: 147452	From 10/01/2011 To 09/30/2012	Part II Date/Time Prepared: 2/26/2013 7:45 am
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		Administrative & General (ACCUM. COST)	
		5.00	
<b>GENERAL SERVICE COST CENTERS</b>			
1.00	Capital Related - Bldg. & Fixtures		1.00
2.00	Capital Related - Movable Equipment		2.00
3.00	Plant Operation & Maintenance		3.00
4.00	Transportation (see instructions)		4.00
5.00	Administrative and General	1,798,780	5.00
<b>HHA REIMBURSABLE SERVICES</b>			
6.00	Skilled Nursing Care	1,065,284	6.00
7.00	Physical Therapy	670,747	7.00
8.00	Occupational Therapy	0	8.00
9.00	Speech Pathology	0	9.00
10.00	Medical Social Services	4,221	10.00
11.00	Home Health Aide	58,528	11.00
12.00	Supplies (see instructions)	0	12.00
13.00	Drugs	0	13.00
14.00	DME	0	14.00
<b>HHA NONREIMBURSABLE SERVICES</b>			
15.00	Home Dialysis Aide Services	0	15.00
16.00	Respiratory Therapy	0	16.00
17.00	Private Duty Nursing	0	17.00
18.00	Clinic	0	18.00
19.00	Health Promotion Activities	0	19.00
20.00	Day Care Program	0	20.00
21.00	Home Delivered Meals Program	0	21.00
22.00	Homemaker Service	0	22.00
23.00	All Others (specify)	0	23.00
24.00	Total (sum of lines 1-23)	1,798,780	24.00
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	514,585	25.00
26.00	Unit Cost Multiplier	0.286074	26.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 140213

Period: From 10/01/2011

Worksheet H-2

HHA CCN: 147452

To 09/30/2012

Part I  
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Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
		1.00	2.00			
	0			4.00	4A	
1.00 Administrative and General	0	0	1,214	476,680	477,894	1.00
2.00 Skilled Nursing Care	1,370,035	0	0	0	1,370,035	2.00
3.00 Physical Therapy	862,630	0	0	0	862,630	3.00
4.00 Occupational Therapy	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	5.00
6.00 Medical Social Services	5,429	0	0	0	5,429	6.00
7.00 Home Health Aide	75,271	0	0	0	75,271	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19) (2)	2,313,365	0	1,214	476,680	2,791,259	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

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS		Provider CCN: 140213	Period: From 10/01/2011	Worksheet H-2
		HHA CCN: 147452	To 09/30/2012	Part I
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Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		5.00	7.00	8.00	9.00	10.00	
1.00	Administrative and General	139,390	0	0	0	0	1.00
2.00	Skilled Nursing Care	399,603	0	0	0	0	2.00
3.00	Physical Therapy	251,608	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	5.00
6.00	Medical Social Services	1,584	0	0	0	0	6.00
7.00	Home Health Aide	21,955	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	814,140	0	0	0	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.						21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 140213

Period:

Worksheet H-2

HHA CCN: 147452

From 10/01/2011  
To 09/30/2012

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Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
1.00	Administrative and General	55,644	124,099	5,707	349	0	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	2.00
3.00	Physical Therapy	0	0	0	0	0	3.00
4.00	Occupational Therapy	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	6.00
7.00	Home Health Aide	0	0	0	0	0	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	55,644	124,099	5,707	349	0	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.						21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 140213

Period: From 10/01/2011

Worksheet H-2

HHA CCN: 147452

To 09/30/2012

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Cost Center Description	SOCIAL SERVICE	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	
	17.00	23.00	24.00	25.00	26.00	
1.00 Administrative and General	0	61,637	864,720	0	864,720	1.00
2.00 Skilled Nursing Care	0	0	1,769,638	0	1,769,638	2.00
3.00 Physical Therapy	0	0	1,114,238	0	1,114,238	3.00
4.00 Occupational Therapy	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	7,013	0	7,013	6.00
7.00 Home Health Aide	0	0	97,226	0	97,226	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19) (2)	0	61,637	3,852,835	0	3,852,835	20.00
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.						21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS		Provider CCN: 140213	Period: From 10/01/2011	Worksheet H-2
		HHA CCN: 147452	To 09/30/2012	Part I
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Cost Center Description		Allocated HHA A&G (see Part II)	Total HHA Costs	
		27.00	28.00	
1.00	Administrative and General			1.00
2.00	Skilled Nursing Care	512,110	2,281,748	2.00
3.00	Physical Therapy	322,445	1,436,683	3.00
4.00	Occupational Therapy	0	0	4.00
5.00	Speech Pathology	0	0	5.00
6.00	Medical Social Services	2,029	9,042	6.00
7.00	Home Health Aide	28,136	125,362	7.00
8.00	Supplies (see instructions)	0	0	8.00
9.00	Drugs	0	0	9.00
10.00	DME	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	11.00
12.00	Respiratory Therapy	0	0	12.00
13.00	Private Duty Nursing	0	0	13.00
14.00	Clinic	0	0	14.00
15.00	Health Promotion Activities	0	0	15.00
16.00	Day Care Program	0	0	16.00
17.00	Home Delivered Meals Program	0	0	17.00
18.00	Homemaker Service	0	0	18.00
19.00	All Others (specify)	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	864,720	3,852,835	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.	0.289386		21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 140213  
HHA CCN: 147452

Period:  
From 10/01/2011  
To 09/30/2012

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Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQ. FEET)	MVBLE EQUIP (DOLLAR VALUE)					
	1.00	2.00	4.00				
1.00 Administrative and General	0	1,193	1,426,805	5A	0	477,894	1.00
2.00 Skilled Nursing Care	0	0	0		0	1,370,035	2.00
3.00 Physical Therapy	0	0	0		0	862,630	3.00
4.00 Occupational Therapy	0	0	0		0	0	4.00
5.00 Speech Pathology	0	0	0		0	0	5.00
6.00 Medical Social Services	0	0	0		0	5,429	6.00
7.00 Home Health Aide	0	0	0		0	75,271	7.00
8.00 Supplies (see instructions)	0	0	0		0	0	8.00
9.00 Drugs	0	0	0		0	0	9.00
10.00 DME	0	0	0		0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0		0	0	11.00
12.00 Respiratory Therapy	0	0	0		0	0	12.00
13.00 Private Duty Nursing	0	0	0		0	0	13.00
14.00 Clinic	0	0	0		0	0	14.00
15.00 Health Promotion Activities	0	0	0		0	0	15.00
16.00 Day Care Program	0	0	0		0	0	16.00
17.00 Home Delivered Meals Program	0	0	0		0	0	17.00
18.00 Homemaker Service	0	0	0		0	0	18.00
19.00 All Others (specify)	0	0	0		0	0	19.00
20.00 Total (sum of lines 1-19)	0	1,193	1,426,805			2,791,259	20.00
21.00 Total cost to be allocated	0	1,214	476,680			814,140	21.00
22.00 Unit cost multiplier	0.000000	1.017603	0.334089			0.291675	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS	Provider CCN: 140213 HHA CCN: 147452	Period: From 10/01/2011 To 09/30/2012	Worksheet H-2 Part II Date/Time Prepared: 2/26/2013 7:45 am PPS
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Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (NUMBER HOUSED)	
	7.00	8.00	9.00	10.00	11.00	
1.00 Administrative and General	0	0	0	0	2,038	1.00
2.00 Skilled Nursing Care	0	0	0	0	0	2.00
3.00 Physical Therapy	0	0	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19)	0	0	0	0	2,038	20.00
21.00 Total cost to be allocated	0	0	0	0	55,644	21.00
22.00 Unit cost multiplier	0.000000	0.000000	0.000000	0.000000	27.303238	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS	Provider CCN: 140213 HHA CCN: 147452	Period: From 10/01/2011 To 09/30/2012	Worksheet H-2 Part II Date/Time Prepared: 2/26/2013 7:45 am PPS
		Home Health Agency I	

Cost Center Description	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	
	(DIRECT NURSING)	(COSTED REQUIS.)				
	13.00	14.00	15.00	16.00	17.00	
1.00 Administrative and General	42,393	39,591	510	0	0	1.00
2.00 Skilled Nursing Care	0	0	0	0	0	2.00
3.00 Physical Therapy	0	0	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19)	42,393	39,591	510	0	0	20.00
21.00 Total cost to be allocated	124,099	5,707	349	0	0	21.00
22.00 Unit cost multiplier	2.927346	0.144149	0.684314	0.000000	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS	Provider CCN: 140213	Period: From 10/01/2011 To 09/30/2012	Worksheet H-2 Part II
	HHA CCN: 147452	Home Health Agency I	Date/Time Prepared: 2/26/2013 7:45 am PPS

Cost Center Description		PARAMED PRGM (ASSIGNED TIME)	
		23.00	
1.00	Administrative and General	230	1.00
2.00	Skilled Nursing Care	0	2.00
3.00	Physical Therapy	0	3.00
4.00	Occupational Therapy	0	4.00
5.00	Speech Pathology	0	5.00
6.00	Medical Social Services	0	6.00
7.00	Home Health Aide	0	7.00
8.00	Supplies (see instructions)	0	8.00
9.00	Drugs	0	9.00
10.00	DME	0	10.00
11.00	Home Dialysis Aide Services	0	11.00
12.00	Respiratory Therapy	0	12.00
13.00	Private Duty Nursing	0	13.00
14.00	Clinic	0	14.00
15.00	Health Promotion Activities	0	15.00
16.00	Day Care Program	0	16.00
17.00	Home Delivered Meals Program	0	17.00
18.00	Homemaker Service	0	18.00
19.00	All Others (specify)	0	19.00
20.00	Total (sum of lines 1-19)	230	20.00
21.00	Total cost to be allocated	61,637	21.00
22.00	Unit cost multiplier	267.986957	22.00

APPORTIONMENT OF PATIENT SERVICE COSTS		Provider CCN: 140213 HHA CCN: 147452		Period: From 10/01/2011 To 09/30/2012		Worksheet H-3 Parts I-II Date/Time Prepared: 2/26/2013 7:45 am	
		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	
		0	1.00	2.00	3.00	4.00	
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION							
Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00	2,281,748		2,281,748	10,483	1.00
2.00	Physical Therapy	3.00	1,436,683	0	1,436,683	6,612	2.00
3.00	Occupational Therapy	4.00	0	0	0	1,725	3.00
4.00	Speech Pathology	5.00	0	0	0	134	4.00
5.00	Medical Social Services	6.00	9,042		9,042	223	5.00
6.00	Home Health Aide	7.00	125,362		125,362	1,441	6.00
7.00	Total (sum of lines 1-6)		3,852,835	0	3,852,835	20,618	7.00
Cost Center Description		Cost Limits	CBSA No. (1)	Part A	Program Visits		
					Part B		
					Not Subject to Deductibles & Coinsurance	Subject to Deductibles	
		0	1.00	2.00	3.00	4.00	
Limitation Cost Computation							
8.00	Skilled Nursing Care		16974	5,982	2,187		8.00
9.00	Physical Therapy		16974	3,883	1,073		9.00
10.00	Occupational Therapy		16974	1,155	254		10.00
11.00	Speech Pathology		16974	82	6		11.00
12.00	Medical Social Services		16974	122	74		12.00
13.00	Home Health Aide		16974	996	478		13.00
14.00	Total (sum of lines 8-13)			12,220	4,072		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 Record)	
		0	1.00	2.00	3.00	4.00	
Supplies and Drugs Cost Computations							
15.00	Cost of Medical Supplies	8.00	0	0	0	13,588	15.00
16.00	Cost of Drugs	9.00	0	0	0	0	16.00
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)		
		0	1.00	2.00	3.00		
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy		66.00	0.389719	0	0	1.00
2.00	Occupational Therapy		67.00	0.249588	0	0	2.00
3.00	Speech Pathology		68.00	0.000000	0	0	3.00
4.00	Cost of Medical Supplies		71.00	0.418855	0	0	4.00
5.00	Cost of Drugs		73.00	0.340200	0	0	5.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 140213

Period: From 10/01/2011

Worksheet H-3

HHA CCN: 147452

To 09/30/2012

Parts I-III  
Date/Time Prepared:  
2/26/2013 7:45 am

Title XVIII

Home Health Agency I

PPS

Cost Center Description	Average Cost Per Visit (col. 3 ÷ col. 4)	Part A	Program Visits			
			Part B			
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		
	5.00	6.00	7.00	8.00		
<b>PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION</b>						
<b>Cost Per Visit Computation</b>						
1.00	Skilled Nursing Care	217.66	5,982	2,187		1.00
2.00	Physical Therapy	217.28	3,883	1,073		2.00
3.00	Occupational Therapy	0.00	1,155	254		3.00
4.00	Speech Pathology	0.00	82	6		4.00
5.00	Medical Social Services	40.55	122	74		5.00
6.00	Home Health Aide	87.00	996	478		6.00
7.00	Total (sum of lines 1-6)		12,220	4,072		7.00
<b>Cost Center Description</b>						
		5.00	6.00	7.00	8.00	9.00
<b>Limitation Cost Computation</b>						
8.00	Skilled Nursing Care					8.00
9.00	Physical Therapy					9.00
10.00	Occupational Therapy					10.00
11.00	Speech Pathology					11.00
12.00	Medical Social Services					12.00
13.00	Home Health Aide					13.00
14.00	Total (sum of lines 8-13)					14.00
<b>Program Covered Charges</b>						
Cost Center Description	Ratio (col. 3 ÷ col. 4)	Part A	Part B			
			Part B			
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		
		5.00	6.00	7.00	8.00	
<b>Supplies and Drugs Cost Computations</b>						
15.00	Cost of Medical Supplies	0.000000				15.00
16.00	Cost of Drugs	0.000000		0	0	16.00
<b>Cost Center Description</b>						
			Transfer to Part I as Indicated			
			4.00			
<b>PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS</b>						
1.00	Physical Therapy	col. 2, line 2.00				1.00
2.00	Occupational Therapy	col. 2, line 3.00				2.00
3.00	Speech Pathology	col. 2, line 4.00				3.00
4.00	Cost of Medical Supplies	col. 2, line 15.00				4.00
5.00	Cost of Drugs	col. 2, line 16.00				5.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 140213  
HHA CCN: 147452

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet H-3  
Parts I-III  
Date/Time Prepared:  
2/26/2013 7:45 am  
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Title XVII

Home Health Agency I

Cost Center Description	Cost of Services			Total Program Cost (sum of col.s. 9-10)	
	Part A	Part B			
		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		
9.00	10.00	11.00	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	1,302,042	476,022	1,778,064	1.00
2.00	Physical Therapy	843,698	233,141	1,076,839	2.00
3.00	Occupational Therapy	0	0	0	3.00
4.00	Speech Pathology	0	0	0	4.00
5.00	Medical Social Services	4,947	3,001	7,948	5.00
6.00	Home Health Aide	86,652	41,586	128,238	6.00
7.00	Total (sum of lines 1-6)	2,237,339	753,750	2,991,089	7.00
Cost Center Description					
		10.00	11.00	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
Cost of Services					
Cost Center Description	Part A	Part B			
		Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance		
	9.00	10.00	11.00		
Supplies and Drugs Cost Computations					
15.00	Cost of Medical Supplies				15.00
16.00	Cost of Drugs		0	0	16.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 140213 HHA CCN: 147452	Period: From 10/01/2011 To 09/30/2012	Worksheet H-4 Part I-II Date/Time Prepared: 2/26/2013 7:45 am
		Title XVII I	Home Health Agency I	PPS
		Part A	Part B	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		1.00	2.00	3.00
<b>PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES</b>				
Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0
2.00	Total charges	2,618,821	883,059	0
Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(b)	0	0	0
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000
6.00	Total customary charges (see instructions)	2,618,821	883,059	0
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	2,618,821	883,059	0
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0
9.00	Primary payer amounts	0	0	0
			Part A Services	Part B Services
			1.00	2.00
<b>PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT</b>				
10.00	Total reasonable cost (see instructions)		0	0
11.00	Total PPS Reimbursement - Full Episodes without Outliers		1,877,328	613,680
12.00	Total PPS Reimbursement - Full Episodes with Outliers		0	5,708
13.00	Total PPS Reimbursement - LUPA Episodes		16,001	8,240
14.00	Total PPS Reimbursement - PEP Episodes		41,928	23,138
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		0	1,411
16.00	Total PPS Outlier Reimbursement - PEP Episodes		1,990	0
17.00	Total Other Payments		0	0
18.00	DME Payments		0	0
19.00	Oxygen Payments		0	0
20.00	Prosthetic and Orthotic Payments		0	0
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	0
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		1,937,247	652,177
23.00	Excess reasonable cost (from line 8)		0	0
24.00	Subtotal (line 22 minus line 23)		1,937,247	652,177
25.00	Coinsurance billed to program patients (from your records)		0	0
26.00	Net cost (line 24 minus line 25)		1,937,247	652,177
27.00	Reimbursable bad debts (from your records)		0	0
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	0
29.00	Total costs - current cost reporting period (line 26 plus line 27)		1,937,247	652,177
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0
31.00	Subtotal (line 29 plus/minus line 30)		1,937,247	652,177
32.00	Interim payments (see instructions)		1,937,247	652,177
33.00	Tentative settlement (for contractor use only)		0	0
34.00	Balance due provider/program (line 31 minus lines 32 and 33)		0	0
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		0	0

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

Provider CCN: 140213

HHA CCN: 147452

Period: From 10/01/2011 To 09/30/2012

Home Health Agency I

Worksheet H-5

Date/Time Prepared: 2/26/2013 7:45 am

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider					1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		1,937,247		652,177	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)		1,937,247		652,177	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)		1,937,247		652,177	7.00
				Contractor Number	Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF RENAL DIALYSIS DEPARTMENT COSTS

Provider CCN: 140213

Period:

Worksheet I-1

Component CCN: 143526

From 10/01/2011  
To 09/30/2012

Date/Time Prepared:  
2/26/2013 7:45 am

Renal Dialysis

		Total Costs	Basis	Statistics	FTEs per 2080 Hours	
		1.00	2.00	3.00	4.00	
1.00	Registered Nurses	1,581,838	Hours of Service	40,773.00	19.60	1.00
2.00	Licensed Practical Nurses	43,199	Hours of Service	1,538.00	0.74	2.00
3.00	Nurses Aides	0	Hours of Service	0.00	0.00	3.00
4.00	Technicians	433,118	Hours of Service	20,994.00	10.09	4.00
5.00	Social Workers	131,805	Hours of Service	3,658.00	1.76	5.00
6.00	Dieticians	144,803	Hours of Service	4,444.00	2.14	6.00
7.00	Physicians	0	Accumulated Cost			7.00
8.00	Non-patient Care Salary	660,465	Accumulated Cost			8.00
9.00	Subtotal (sum of lines 1-8)	2,995,228				9.00
10.00	Employee Benefits	0	Salary			10.00
11.00	Capital Related Costs-Bldgs. & Fixtures	0	Square Feet			11.00
12.00	Capital Related Costs-Mov. Equip.	0	Percentage of Time			12.00
13.00	Machine Costs & Repairs	0	Percentage of Time			13.00
14.00	Supplies	743,077	Requisitions			14.00
15.00	Drugs	1,489,396	Requisitions			15.00
16.00	Other	528,467	Accumulated Cost			16.00
17.00	Subtotal (sum of lines 9-16)*	5,756,168				17.00
18.00	Capital Related Costs-Bldgs. & Fixtures	188,493	Square Feet			18.00
19.00	Capital Related Costs-Mov. Equip.	58,831	Percentage of Time			19.00
20.00	Employee Benefits	1,000,673	Salary			20.00
21.00	Administrative & General	2,042,940	Accumulated Cost			21.00
22.00	Maint./Repairs-Oper-Housekeeping	220,922	Square Feet			22.00
23.00	Medical Education Program Costs	0				23.00
24.00	Central Service & Supplies	106,230	Requisitions			24.00
25.00	Pharmacy	1,019,499	Requisitions			25.00
26.00	Other Allocated Costs	376,426	Accumulated Cost			26.00
27.00	Subtotal (sum of lines 17-26)*	10,770,182				27.00
28.00	Laboratory (see instructions)	0	Charges	0		28.00
29.00	Respiratory Therapy (see instructions)	0	Charges	0		29.00
30.00	Other (see instructions)	0	Charges	0		30.00
31.00	Total costs (sum of lines 27-30)	10,770,182				31.00

\* Line 17, column 1 should agree with Worksheet A, column 7 for line 74 or line 94 as appropriate, and line 27, column 1 should agree with Worksheet B, Part I, column 26 for line 74 or line 94 as appropriate.

ALLOCATION OF RENAL DEPARTMENT COSTS TO TREATMENT MODALITIES

Provider CCN: 140213

Period: From 10/01/2011

Worksheet 1-2

Component CCN: 143526

To 09/30/2012

Date/Time Prepared: 2/26/2013 7:45 am

		Capital Related Costs		Direct Patient Care Salary		Employee Benefits	
		Builing	Equipment	RNs	Other		
		1.00	2.00	3.00	4.00		
1.00	Total Renal Department Costs	409,415	58,831	1,581,838	752,925	1,000,673	1.00
<b>MAINTENANCE</b>							
2.00	Hemodialysis	409,415	58,831	1,365,976	726,504	881,895	2.00
3.00	Intermittent Peritoneal	0	0	0	0	0	3.00
<b>TRAINING</b>							
4.00	Hemodialysis	0	0	0	0	0	4.00
5.00	Intermittent Peritoneal	0	0	0	0	0	5.00
6.00	CAPD	0	0	0	0	0	6.00
7.00	CCDP	0	0	0	0	0	7.00
<b>HOME</b>							
8.00	Hemodialysis	0	0	0	0	0	8.00
9.00	Intermittent Peritoneal	0	0	0	0	0	9.00
10.00	CAPD	0	0	0	0	0	10.00
11.00	CCDP	0	0	0	0	0	11.00
<b>OTHER BILLABLE SERVICES</b>							
12.00	Inpatient Dialysis	0	0	215,862	26,421	118,778	12.00
13.00	Method II Home Patient	0	0	0	0	0	13.00
14.00	EPO (include in Renal Department)						14.00
15.00	ARANESP (include in Renal Department)						15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Total (sum of lines 2-16)	409,415	58,831	1,581,838	752,925	1,000,673	17.00
18.00	Medical Educational Program Costs						18.00
19.00	Total Renal Costs (line 17 + line 18)						19.00

ALLOCATION OF RENAL DEPARTMENT COSTS TO TREATMENT MODALITIES		Provider CCN: 140213	Period: From 10/01/2011	Worksheet 1-2
		Component CCN: 143526	To 09/30/2012	Date/Time Prepared: 2/26/2013 7:45 am

		Drugs	Medical Supplies	Routine Ancillary Services	Subtotal (sum of cols. 1-8)	Overhead	
		6.00	7.00	8.00	9.00	10.00	
1.00	Total Renal Department Costs	2,508,895	849,307	0	7,161,884	3,608,298	1.00
<b>MAINTENANCE</b>							
2.00	Hemodialysis	2,508,895	849,307	0	6,800,823	3,426,388	2.00
3.00	Intermittent Peritoneal	0	0	0	0	0	3.00
<b>TRAINING</b>							
4.00	Hemodialysis	0	0	0	0	0	4.00
5.00	Intermittent Peritoneal	0	0	0	0	0	5.00
6.00	CAPD	0	0	0	0	0	6.00
7.00	CCDP	0	0	0	0	0	7.00
<b>HOME</b>							
8.00	Hemodialysis	0	0	0	0	0	8.00
9.00	Intermittent Peritoneal	0	0	0	0	0	9.00
10.00	CAPD	0	0	0	0	0	10.00
11.00	CCDP	0	0	0	0	0	11.00
<b>OTHER BILLABLE SERVICES</b>							
12.00	Inpatient Dialysis	0	0	0	361,061	181,910	12.00
13.00	Method II Home Patient	0	0	0	0	0	13.00
14.00	EPO (include in Renal Department)	0	0	0	0	0	14.00
15.00	ARANESP (include in Renal Department)	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Total (sum of lines 2-16)	2,508,895	849,307	0	7,161,884	3,608,298	17.00
18.00	Medical Educational Program Costs						18.00
19.00	Total Renal Costs (line 17 + line 18)						19.00

ALLOCATION OF RENAL DEPARTMENT COSTS TO TREATMENT MODALITIES		Provider CCN: 140213	Period: From 10/01/2011	Worksheet 1-2
		Component CCN: 143526	To 09/30/2012	Date/Time Prepared: 2/26/2013 7:45 am
			Renal Dialysis	

		Total (col. 9 + col. 10) 11.00	
1.00	Total Renal Department Costs	10,770,182	1.00
<b>MAINTENANCE</b>			
2.00	Hemodialysis	10,227,211	2.00
3.00	Intermittent Peritoneal	0	3.00
<b>TRAINING</b>			
4.00	Hemodialysis	0	4.00
5.00	Intermittent Peritoneal	0	5.00
6.00	CAPD	0	6.00
7.00	CCDP	0	7.00
<b>HOME</b>			
8.00	Hemodialysis	0	8.00
9.00	Intermittent Peritoneal	0	9.00
10.00	CAPD	0	10.00
11.00	CCDP	0	11.00
<b>OTHER BILLABLE SERVICES</b>			
12.00	Inpatient Dialysis	542,971	12.00
13.00	Method II Home Patient	0	13.00
14.00	EPO (include in Renal Department)		14.00
15.00	ARANESP (include in Renal Department)		15.00
16.00	Other	0	16.00
17.00	Total (sum of lines 2-16)	10,770,182	17.00
18.00	Medical Educational Program Costs	0	18.00
19.00	Total Renal Costs (line 17 + line 18)	10,770,182	19.00

DIRECT AND INDIRECT RENAL DIALYSIS COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140213  
Component CCN: 143526

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet 1-3  
Date/Time Prepared:  
2/26/2013 7:45 am

		Capital Related Costs		Direct Patient Care Salary			
		Building (Square Feet)	Equipment (% of Time)	RNs (Hours)	Other (Hours)		
		0	1.00	2.00	3.00	4.00	
1.00	Total Renal Department Costs		409,415	58,831	1,581,838	752,925	1.00
<b>MAINTENANCE</b>							
2.00	Hemodialysis		19,984	100.00	35,209.00	29,559.00	2.00
3.00	Intermittent Peritoneal		0	0.00	0.00	0.00	3.00
<b>TRAINING</b>							
4.00	Hemodialysis		0	0.00	0.00	0.00	4.00
5.00	Intermittent Peritoneal		0	0.00	0.00	0.00	5.00
6.00	CAPD		0	0.00	0.00	0.00	6.00
7.00	CCDP		0	0.00	0.00	0.00	7.00
<b>HOME</b>							
8.00	Hemodialysis		0	0.00	0.00	0.00	8.00
9.00	Intermittent Peritoneal		0	0.00	0.00	0.00	9.00
10.00	CAPD		0	0.00	0.00	0.00	10.00
11.00	CCDP		0	0.00	0.00	0.00	11.00
<b>OTHER BILLABLE SERVICES</b>							
12.00	Inpatient Dialysis Treatments	594,117	0	0.00	5,564.00	1,075.00	12.00
13.00	Method II Home Patient		0	0.00	0.00	0.00	13.00
14.00	EPO						14.00
15.00	ARANESP						15.00
16.00	Other		0	0.00	0.00	0.00	16.00
17.00	Total Statistical Basis		19,984	100.00	40,773.00	30,634.00	17.00
18.00	Unit Cost Multiplier (line 1 ÷ line 17)		20.487140	588.310000	38.796213	24.578083	18.00

DIRECT AND INDIRECT RENAL DIALYSIS COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140213  
Component CCN: 143526

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet 1-3  
Date/Time Prepared:  
2/26/2013 7:45 am

		Renal Dialysis				Subtotal	
		Employee Benefits (Salary)	Drugs (Requist.)	Medical Supplies (Requist.)	Routine Ancillary Services (Charges)		
		5.00	6.00	7.00	8.00	9.00	
1.00	Total Renal Department Costs	1,000,673	2,508,895	849,307	0	7,161,884	1.00
<b>MAINTENANCE</b>							
2.00	Hemodialysis	2,371,563	1,502,249	743,077	0		2.00
3.00	Intermittent Peritoneal	0	0	0	0		3.00
<b>TRAINING</b>							
4.00	Hemodialysis	0	0	0	0		4.00
5.00	Intermittent Peritoneal	0	0	0	0		5.00
6.00	CAPD	0	0	0	0		6.00
7.00	CCDP	0	0	0	0		7.00
<b>HOME</b>							
8.00	Hemodialysis	0	0	0	0		8.00
9.00	Intermittent Peritoneal	0	0	0	0		9.00
10.00	CAPD	0	0	0	0		10.00
11.00	CCDP	0	0	0	0		11.00
<b>OTHER BILLABLE SERVICES</b>							
12.00	Inpatient Dialysis Treatments	319,415	0	0	0		12.00
13.00	Method II Home Patient	0	0	0	0		13.00
14.00	EPO		0				14.00
15.00	ARANESP		0				15.00
16.00	Other	0	0	0	0		16.00
17.00	Total Statistical Basis	2,690,978	1,502,249	743,077	0		17.00
18.00	Unit Cost Multiplier (line 1 ÷ line 17)	0.371862	1.670093	1.142960	0.000000		18.00

DIRECT AND INDIRECT RENAL DIALYSIS COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140213

Period: From 10/01/2011

Worksheet 1-3

Component CCN: 143526

To 09/30/2012

Date/Time Prepared: 2/26/2013 7:45 am

Renal Dialysis

		Overhead (Accum. Cost)	
		10.00	
1.00	Total Renal Department Costs	3,608,298	1.00
<b>MAINTENANCE</b>			
2.00	Hemodialysis		2.00
3.00	Intermittent Peritoneal		3.00
<b>TRAINING</b>			
4.00	Hemodialysis		4.00
5.00	Intermittent Peritoneal		5.00
6.00	CAPD		6.00
7.00	CCDP		7.00
<b>HOME</b>			
8.00	Hemodialysis		8.00
9.00	Intermittent Peritoneal		9.00
10.00	CAPD		10.00
11.00	CCDP		11.00
<b>OTHER BILLABLE SERVICES</b>			
12.00	Inpatient Dialysis Treatments		12.00
13.00	Method II Home Patient		13.00
14.00	EPO		14.00
15.00	ARANESP		15.00
16.00	Other		16.00
17.00	Total Statistical Basis	7,161,884	17.00
18.00	Unit Cost Multiplier (line 1 ÷ line 17)	0.503820	18.00

COMPUTATION OF AVERAGE COST PER TREATMENT FOR OUTPATIENT RENAL DIALYSIS

Provider CCN: 140213  
Component CCN: 143526

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet 1-4  
Date/Time Prepared:  
2/26/2013 7:45 am

		Rate 0			Renal Dialysis		
		Number of Total Treatments	Total Cost (from Wkst. 1-2, col. 11)	Average Cost of Program Treatments (col. 2 ÷ col. 1)	Number of Program Treatments	Total Program Expenses (col. 4 x col. 3)	
		1.00	2.00	3.00	4.00	5.00	
1.00	Maintenance - Hemodialysis	12,538	10,227,211	815.70	951	775,731	1.00
2.00	Maintenance - Peritoneal Dialysis	0	0	0.00	0	0	2.00
3.00	Training - Hemodialysis	0	0	0.00	0	0	3.00
4.00	Training - Peritoneal Dialysis	0	0	0.00	0	0	4.00
5.00	Training - Continuous Ambulatory Peritoneal Dialysis	0	0	0.00	0	0	5.00
6.00	Training - Continuous Cycling Peritoneal Dialysis	0	0	0.00	0	0	6.00
7.00	Home Program - Hemodialysis	0	0	0.00	0	0	7.00
8.00	Home Program - Peritoneal Dialysis	0	0	0.00	0	0	8.00
		Patient Weeks			Patient Weeks		
		1.00	2.00	3.00	4.00	5.00	
9.00	Home Program - Continuous Ambulatory Peritoneal Dialysis	0	0	0.00	0	0	9.00
10.00	Home Program - Continuous Cycling Peritoneal Dialysis	0	0	0.00	0	0	10.00
11.00	Totals (sum of lines 1-8, columns 1 and 4) (sum of lines 1-10, columns 2, 5, and 6)	12,538	10,227,211		951	775,731	11.00

COMPUTATION OF AVERAGE COST PER TREATMENT FOR OUTPATIENT RENAL DIALYSIS

Provider CCN: 140213  
Component CCN: 143526

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet 1-4  
Date/Time Prepared:  
2/26/2013 7:45 am

		Total Program Payment	Average Payment Rate (col. 6 ÷ col. 4)	Rate 0	Renal Dialysis
		6.00	7.00		
1.00	Maintenance - Hemodialysis	1,512,977	1,590.93		1.00
2.00	Maintenance - Peritoneal Dialysis	0	0.00		2.00
3.00	Training - Hemodialysis	0	0.00		3.00
4.00	Training - Peritoneal Dialysis	0	0.00		4.00
5.00	Training - Continuous Ambulatory Peritoneal Dialysis	0	0.00		5.00
6.00	Training - Continuous Cycling Peritoneal Dialysis	0	0.00		6.00
7.00	Home Program - Hemodialysis	0	0.00		7.00
8.00	Home Program - Peritoneal Dialysis	0	0.00		8.00
		6.00	7.00		
9.00	Home Program - Continuous Ambulatory Peritoneal Dialysis	0	0.00		9.00
10.00	Home Program - Continuous Cycling Peritoneal Dialysis	0	0.00		10.00
11.00	Totals (sum of lines 1-8, columns 1 and 4) (sum of lines 1-10, columns 2, 5, and 6)	1,512,977			11.00

ANALYSIS OF RENAL DIALYSIS DEPARTMENT COSTS

Provider CCN: 140213

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet I-1

Date/Time Prepared:  
2/26/2013 7:45 am

Home Program  
Dialysis

PPS

		Total Costs	Bas is	Statist ics	FTEs per 2080 Hours	
		1.00	2.00	3.00	4.00	
1.00	Registered Nurses	178,730	Hours of Service	1,765.00	0.85	1.00
2.00	Licensed Practical Nurses	0	Hours of Service	0.00	0.00	2.00
3.00	Nurses Aides	0	Hours of Service	0.00	0.00	3.00
4.00	Technicians	0	Hours of Service	0.00	0.00	4.00
5.00	Social Workers	0	Hours of Service	0.00	0.00	5.00
6.00	Dieticians	0	Hours of Service	0.00	0.00	6.00
7.00	Physicians	0	Accumulated Cost			7.00
8.00	Non-patient Care Salary	0	Accumulated Cost			8.00
9.00	Subtotal (sum of lines 1-8)	178,730				9.00
10.00	Employee Benefits	0	Salary			10.00
11.00	Capital Related Costs-Bldgs. & Fixtures	0	Square Feet			11.00
12.00	Capital Related Costs-Mov. Equip.	0	Percentage of Time			12.00
13.00	Machine Costs & Repairs	0	Percentage of Time			13.00
14.00	Supplies	148,775	Requisitions			14.00
15.00	Drugs	19,492	Requisitions			15.00
16.00	Other	0	Accumulated Cost			16.00
17.00	Subtotal (sum of lines 9-16)*	346,997				17.00
18.00	Capital Related Costs-Bldgs. & Fixtures	0	Square Feet			18.00
19.00	Capital Related Costs-Mov. Equip.	0	Percentage of Time			19.00
20.00	Employee Benefits	26,318	Salary			20.00
21.00	Administrative & General	108,887	Accumulated Cost			21.00
22.00	Maint./Repairs-Oper-Housekeeping	0	Square Feet			22.00
23.00	Medical Education Program Costs	0				23.00
24.00	Central Service & Supplies	31,309	Requisitions			24.00
25.00	Pharmacy	13,342	Requisitions			25.00
26.00	Other Allocated Costs	0	Accumulated Cost			26.00
27.00	Subtotal (sum of lines 17-26)*	526,853				27.00
28.00	Laboratory (see instructions)	0	Charges	0		28.00
29.00	Respiratory Therapy (see instructions)	0	Charges	0		29.00
30.00	Other (see instructions)	0	Charges	0		30.00
31.00	Total costs (sum of lines 27-30)	526,853				31.00

\* Line 17, column 1 should agree with Worksheet A, column 7 for line 74 or line 94 as appropriate, and line 27, column 1 should agree with Worksheet B, Part I, column 26 for line 74 or line 94 as appropriate.

ALLOCATION OF RENAL DEPARTMENT COSTS TO TREATMENT MODALITIES		Provider CCN: 140213	Period: From 10/01/2011 To 09/30/2012	Worksheet 1-2 Date/Time Prepared: 2/26/2013 7:45 am
			Home Program Dialysis	PPS

		Capital Related Costs		Direct Patient Care Salary		Employee Benefits	
		Buiding	Equipment	RNs	Other		
		1.00	2.00	3.00	4.00		
1.00	Total Renal Department Costs	0	0	178,730	0	26,318	1.00
<b>MAINTENANCE</b>							
2.00	Hemodialysis	0	0	178,730	0	26,318	2.00
3.00	Intermittent Peritoneal	0	0	0	0	0	3.00
<b>TRAINING</b>							
4.00	Hemodialysis	0	0	0	0	0	4.00
5.00	Intermittent Peritoneal	0	0	0	0	0	5.00
6.00	CAPD	0	0	0	0	0	6.00
7.00	CCDP	0	0	0	0	0	7.00
<b>HOME</b>							
8.00	Hemodialysis	0	0	0	0	0	8.00
9.00	Intermittent Peritoneal	0	0	0	0	0	9.00
10.00	CAPD	0	0	0	0	0	10.00
11.00	CCDP	0	0	0	0	0	11.00
<b>OTHER BILLABLE SERVICES</b>							
12.00	Inpatient Dialysis	0	0	0	0	0	12.00
13.00	Method II Home Patient	0	0	0	0	0	13.00
14.00	EPO (include in Renal Department)						14.00
15.00	ARANESP (include in Renal Department)						15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Total (sum of lines 2-16)	0	0	178,730	0	26,318	17.00
18.00	Medical Educational Program Costs						18.00
19.00	Total Renal Costs (line 17 + line 18)						19.00

ALLOCATION OF RENAL DEPARTMENT COSTS TO TREATMENT MODALITIES		Provider CCN: 140213		Period: From 10/01/2011 To 09/30/2012		Worksheet 1-2 Date/Time Prepared: 2/26/2013 7:45 am	
				Home Program Di al ysi s		PPS	
		Drugs	Medi cal Suppl i es	Routi ne Ancil l ary Servi ces	Subtotal (sum of col s. 1-8)	Overhead	
		6.00	7.00	8.00	9.00	10.00	
1.00	Total Renal Department Costs	32,834	180,084	0	417,966	108,887	1.00
<b>MAINTENANCE</b>							
2.00	Hemodi al ysi s	32,834	180,084	0	417,966	108,887	2.00
3.00	Intermi ttent Peri toneal	0	0	0	0	0	3.00
<b>TRAI NI NG</b>							
4.00	Hemodi al ysi s	0	0	0	0	0	4.00
5.00	Intermi ttent Peri toneal	0	0	0	0	0	5.00
6.00	CAPD	0	0	0	0	0	6.00
7.00	CCDP	0	0	0	0	0	7.00
<b>HOME</b>							
8.00	Hemodi al ysi s	0	0	0	0	0	8.00
9.00	Intermi ttent Peri toneal	0	0	0	0	0	9.00
10.00	CAPD	0	0	0	0	0	10.00
11.00	CCDP	0	0	0	0	0	11.00
<b>OTHER BILLABLE SERVICES</b>							
12.00	Inpatient Di al ysi s	0	0	0	0	0	12.00
13.00	Method II Home Patient	0	0	0	0	0	13.00
14.00	EPO (include in Renal Department)	0	0	0	0	0	14.00
15.00	ARANESP (include in Renal Department)	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Total (sum of lines 2-16)	32,834	180,084	0	417,966	108,887	17.00
18.00	Medical Educational Program Costs						18.00
19.00	Total Renal Costs (line 17 + line 18)						19.00

ALLOCATION OF RENAL DEPARTMENT COSTS TO TREATMENT MODALITIES		Provider CCN: 140213	Period: From 10/01/2011 To 09/30/2012	Worksheet 1-2 Date/Time Prepared: 2/26/2013 7:45 am
			Home Program Dialysis	PPS

		Total (col. 9 + col. 10)	
		11.00	
1.00	Total Renal Department Costs	526,853	1.00
MAINTENANCE			
2.00	Hemodialysis	526,853	2.00
3.00	Intermittent Peritoneal	0	3.00
TRAINING			
4.00	Hemodialysis	0	4.00
5.00	Intermittent Peritoneal	0	5.00
6.00	CAPD	0	6.00
7.00	CCDP	0	7.00
HOME			
8.00	Hemodialysis	0	8.00
9.00	Intermittent Peritoneal	0	9.00
10.00	CAPD	0	10.00
11.00	CCDP	0	11.00
OTHER BILLABLE SERVICES			
12.00	Inpatient Dialysis	0	12.00
13.00	Method II Home Patient	0	13.00
14.00	EPO (include in Renal Department)		14.00
15.00	ARANESP (include in Renal Department)		15.00
16.00	Other	0	16.00
17.00	Total (sum of lines 2-16)	526,853	17.00
18.00	Medical Educational Program Costs	0	18.00
19.00	Total Renal Costs (line 17 + line 18)	526,853	19.00

DIRECT AND INDIRECT RENAL DIALYSIS COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 140213		Period: From 10/01/2011 To 09/30/2012		Worksheet 1-3	
				Home Program Dialysis		Date/Time Prepared: 2/26/2013 7:45 am	
		Capital Related Costs		Direct Patient Care Salary			
		Bui l di ng (Square Feet)	Equipment (% of Time)	RNs (Hours)	Other (Hours)		
		0	1.00	2.00	3.00	4.00	
1.00	Total Renal Department Costs		0	0	178,730	0	1.00
MAINTENANCE							
2.00	Hemodialysis		0	0.00	1,765.00	1.00	2.00
3.00	Intermittent Peritoneal		0	0.00	0.00	0.00	3.00
TRAINING							
4.00	Hemodialysis		0	0.00	0.00	0.00	4.00
5.00	Intermittent Peritoneal		0	0.00	0.00	0.00	5.00
6.00	CAPD		0	0.00	0.00	0.00	6.00
7.00	CCDP		0	0.00	0.00	0.00	7.00
HOME							
8.00	Hemodialysis		0	0.00	0.00	0.00	8.00
9.00	Intermittent Peritoneal		0	0.00	0.00	0.00	9.00
10.00	CAPD		0	0.00	0.00	0.00	10.00
11.00	CCDP		0	0.00	0.00	0.00	11.00
OTHER BILLABLE SERVICES							
12.00	Inpatient Dialysis Treatments	0	0	0.00	0.00	0.00	12.00
13.00	Method II Home Patient		0	0.00	0.00	0.00	13.00
14.00	EPO						14.00
15.00	ARANESP						15.00
16.00	Other		0	0.00	0.00	0.00	16.00
17.00	Total Statistical Basis		0	0.00	1,765.00	1.00	17.00
18.00	Unit Cost Multiplier (line 1 ÷ line 17)		0.000000	0.000000	101.263456	0.000000	18.00

DIRECT AND INDIRECT RENAL DIALYSIS COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 140213		Period: From 10/01/2011 To 09/30/2012		Worksheet 1-3 Date/Time Prepared: 2/26/2013 7:45 am	
				Home Program Dialysis		PPS	
	Employee Benefits (Salary)	Drugs (Requist.)	Medical Supplies (Requist.)	Routine Ancillary Services (Charges)	Subtotal		
	5.00	6.00	7.00	8.00	9.00		
1.00	Total Renal Department Costs	26,318	32,834	180,084	0	417,966	1.00
MAINTENANCE							
2.00	Hemodialysis	309,235	19,492	18,823	0		2.00
3.00	Intermittent Peritoneal	0	0	0	0		3.00
TRAINING							
4.00	Hemodialysis	0	0	0	0		4.00
5.00	Intermittent Peritoneal	0	0	0	0		5.00
6.00	CAPD	0	0	0	0		6.00
7.00	CCDP	0	0	0	0		7.00
HOME							
8.00	Hemodialysis	0	0	0	0		8.00
9.00	Intermittent Peritoneal	0	0	0	0		9.00
10.00	CAPD	0	0	0	0		10.00
11.00	CCDP	0	0	0	0		11.00
OTHER BILLABLE SERVICES							
12.00	Inpatient Dialysis Treatments	0	0	0	0		12.00
13.00	Method II Home Patient	0	0	0	0		13.00
14.00	EPO		0				14.00
15.00	ARANESP		0				15.00
16.00	Other	0	0	0	0		16.00
17.00	Total Statistical Basis	309,235	19,492	18,823	0		17.00
18.00	Unit Cost Multiplier (line 1 ÷ line 17)	0.085107	1.684486	9.567232	0.000000		18.00

DIRECT AND INDIRECT RENAL DIALYSIS COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 140213	Period: From 10/01/2011 To 09/30/2012	Worksheet 1-3 Date/Time Prepared: 2/26/2013 7:45 am
			Home Program Dialysis	PPS

		Overhead (Accum. Cost)	
		10.00	
1.00	Total Renal Department Costs	108,887	1.00
MAINTENANCE			
2.00	Hemodialysis		2.00
3.00	Intermittent Peritoneal		3.00
TRAINING			
4.00	Hemodialysis		4.00
5.00	Intermittent Peritoneal		5.00
6.00	CAPD		6.00
7.00	CCDP		7.00
HOME			
8.00	Hemodialysis		8.00
9.00	Intermittent Peritoneal		9.00
10.00	CAPD		10.00
11.00	CCDP		11.00
OTHER BILLABLE SERVICES			
12.00	Inpatient Dialysis Treatments		12.00
13.00	Method II Home Patient		13.00
14.00	EPO		14.00
15.00	ARANESP		15.00
16.00	Other		16.00
17.00	Total Statistical Basis	417,966	17.00
18.00	Unit Cost Multiplier (line 1 ÷ line 17)	0.260516	18.00

COMPUTATION OF AVERAGE COST PER TREATMENT FOR OUTPATIENT RENAL DIALYSIS

Provider CCN: 140213

Period:  
From 10/01/2011  
To 09/30/2012

Worksheet 1-4

Date/Time Prepared:  
2/26/2013 7:45 am

Rate 0

Home Program  
Dialysis

PPS

		Number of Total Treatments	Total Cost (from Wkst. 1-2, col. 11)	Average Cost of Program Treatments (col. 2 ÷ col. 1)	Number of Program Treatments	Total Program Expenses (col. 4 x col. 3)	
		1.00	2.00	3.00	4.00	5.00	
1.00	Maintenance - Hemodialysis	469	526,853	1,123.35	3	3,370	1.00
2.00	Maintenance - Peritoneal Dialysis	0	0	0.00	0	0	2.00
3.00	Training - Hemodialysis	0	0	0.00	0	0	3.00
4.00	Training - Peritoneal Dialysis	15	0	0.00	0	0	4.00
5.00	Training - Continuous Ambulatory Peritoneal Dialysis	2	0	0.00	0	0	5.00
6.00	Training - Continuous Cycling Peritoneal Dialysis	0	0	0.00	0	0	6.00
7.00	Home Program - Hemodialysis	0	0	0.00	0	0	7.00
8.00	Home Program - Peritoneal Dialysis	0	0	0.00	0	0	8.00
		Patient Weeks			Patient Weeks		
		1.00	2.00	3.00	4.00	5.00	
9.00	Home Program - Continuous Ambulatory Peritoneal Dialysis	0	0	0.00	0	0	9.00
10.00	Home Program - Continuous Cycling Peritoneal Dialysis	0	0	0.00	0	0	10.00
11.00	Totals (sum of lines 1-8, columns 1 and 4) (sum of lines 1-10, columns 2, 5, and 6)	486	526,853		3	3,370	11.00

COMPUTATION OF AVERAGE COST PER TREATMENT FOR OUTPATIENT RENAL DIALYSIS		Provider CCN: 140213	Period: From 10/01/2011 To 09/30/2012	Worksheet 1-4 Date/Time Prepared: 2/26/2013 7:45 am
		Rate 0	Home Program Dialysis	PPS

		Total Program Payment	Average Payment Rate (col. 6 ÷ col. 4)	
		6.00	7.00	
1.00	Maintenance - Hemodialysis	435	145.00	1.00
2.00	Maintenance - Peritoneal Dialysis	0	0.00	2.00
3.00	Training - Hemodialysis	0	0.00	3.00
4.00	Training - Peritoneal Dialysis	0	0.00	4.00
5.00	Training - Continuous Ambulatory Peritoneal Dialysis	0	0.00	5.00
6.00	Training - Continuous Cycling Peritoneal Dialysis	0	0.00	6.00
7.00	Home Program - Hemodialysis	0	0.00	7.00
8.00	Home Program - Peritoneal Dialysis	0	0.00	8.00
		6.00	7.00	
9.00	Home Program - Continuous Ambulatory Peritoneal Dialysis	0	0.00	9.00
10.00	Home Program - Continuous Cycling Peritoneal Dialysis	0	0.00	10.00
11.00	Totals (sum of lines 1-8, columns 1 and 4) (sum of lines 1-10, columns 2, 5, and 6)	435		11.00

CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B		Provider CCN: 140213	Period: From 10/01/2011 To 09/30/2012	Worksheet I-5 Date/Time Prepared: 2/26/2013 7:45 am
				1.00
1.00	Total expenses related to care of program beneficiaries (see instructions)			779,101 1.00
2.00	Total payment (from Worksheet I-4, column 6, line 11)			1,513,412 2.00
3.00	Deductibles billed to Medicare (Part B) patients			275 3.00
4.00	Coinsurance billed to Medicare (Part B) patients			100,910 4.00
5.00	Bad debts for deductibles and coinsurance, net of bad debt recoveries			0 5.00
6.00				6.00
7.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			0 7.00
8.00	Net deductibles and coinsurance billed to Medicare (Part B) patients (sum of lines 3 and 4 less line 5)			101,185 8.00
9.00	Program payment (line 2 less line 3, times 80 percent)			1,210,510 9.00
10.00	Unrecovered from Medicare (Part B) patients (Line 1 minus the sum of lines 8 and 9. If negative, enter zero and do not complete line 11.)			0 10.00
11.00	Reimbursable bad debts (lesser of line 10 or line 5) (transfer to Worksheet E, Part B, line 33)			0 11.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 140213	Period: From 10/01/2011 To 09/30/2012	Worksheet L Parts I-III Date/Time Prepared: 2/26/2013 7:45 am
		Title XVII	Hospital	PPS
				1.00
<b>PART I - FULLY PROSPECTIVE METHOD</b>				
<b>CAPITAL FEDERAL AMOUNT</b>				
1.00	Capital DRG other than outlier		3,797,196	1.00
2.00	Capital DRG outlier payments		136,577	2.00
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		144.26	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 (line 1 times line 5)		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)		4.22	7.00
8.00	Percentage of Medicaid patient days to total days reported on Worksheet S-3, Part I (see instructions)		14.93	8.00
9.00	Sum of lines 7 and 8		19.15	9.00
10.00	Allowable disproportionate share percentage (see instructions)		3.95	10.00
11.00	Disproportionate share adjustment (line 1 times line 10)		149,989	11.00
12.00	Total prospective capital payments (sum of lines 1-2, 6, and 11)		4,083,762	12.00
				1.00
<b>PART II - PAYMENT UNDER REASONABLE COST</b>				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
				1.00
<b>PART III - COMPUTATION OF EXCEPTION PAYMENTS</b>				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00