



COMPU-MAX

PALOS COMMUNITY HOSPITAL Provider CCN: 14-0062	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 08:45 Version: 2014.03
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY

WORKSHEET S
PARTS I, II & III

PART I - COST REPORT STATUS

PROVIDER USE ONLY	1. <input type="checkbox"/> ELECTRONICALLY FILED COST REPORT DATE: 05/28/2014 TIME: 08:45 2. <input checked="" type="checkbox"/> MANUALLY SUBMITTED COST REPORT 3. <input type="checkbox"/> IF THIS IS AN AMENDED REPORT ENTER THE NUMBER OF TIMES THE PROVIDER RESUBMITTED THE COST REPORT 4. <input checked="" 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: _____ 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 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 PALOS COMMUNITY HOSPITAL (14-0062) {(PROVIDER NAME(S) AND NUMBER(S)} FOR THE COST REPORTING PERIOD BEGINNING 01/01/2013 AND ENDING 12/31/2013, AND TO THE BEST OF MY KNOWLEDGE AND BELIEF, IT IS A TRUE, CORRECT AND COMPLETE STATEMENT 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

PART III - SETTLEMENT SUMMARY

		TITLE XVIII					
		TITLE V	PART A	PART B	HIT	TITLE XIX	
		1	2	3	4	5	
1	HOSPITAL		101,649	88,320	-58,681	5,014	1
2	SUBPROVIDER - IPF		53,131				2
3	SUBPROVIDER - IRF						3
4	SUBPROVIDER (OTHER)						4
5	SWING BED - SNF						5
6	SWING BED - NF						6
7	SKILLED NURSING FACILITY						7
8	NURSING FACILITY						8
9	HOME HEALTH AGENCY						9
10	HEALTH CLINIC - RHC						10
11	HEALTH CLINIC - FQHC						11
12	OUTPATIENT REHABILITATION PROVIDER						12
200	TOTAL		154,780	88,320	-58,681	5,014	200

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 THIS 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 THIS 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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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

HOSPITAL AND HOSPITAL HEALTHCARE COMPLEX ADDRESS:										
1	STREET: 12251 S. 80TH AVENUE		P.O. BOX:							1
2	CITY: PALOS HEIGHTS		STATE: IL	ZIP CODE: 60463	COUNTY: COOK					2
HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:										
							PAYMENT SYSTEM (P, T, O, OR N)			
0	1	2	3	4	5	6	7	8	9	
COMPONENT	COMPONENT NAME	CCN NUMBER	CBSA NUMBER	PROV- IDER TYPE	DATE CERTIFIED	V	XVIII	XIX		
3	HOSPITAL	PALOS COMMUNITY HOSPITAL	14-0062	16974	1	07/01/1966	N	P	P	3
4	SUBPROVIDER - IPF	PALOS COMMUNITY HOSPITAL PSYCH	14-S062	16974	4	01/01/1984	N	P	O	4
5	SUBPROVIDER - IRF									5
6	SUBPROVIDER - (OTHER)									6
7	SWING BEDS - SNF									7
8	SWING BEDS - NF									8
9	HOSPITAL-BASED SNF									9
10	HOSPITAL-BASED NF									10
11	HOSPITAL-BASED OLTC									11
12	HOSPITAL-BASED HHA	PALOS COMMUNITY HOSPITAL HHA	14-7470	16974		10/27/1987	N	P	N	12
13	SEPARATELY CERTIFIED ASC									13
14	HOSPITAL-BASED HOSPICE	PALOS COMMUNITY HOSPITAL HOSPICE	14-1591	16974		06/06/1997				14
15	HOSPITAL-BASED HEALTH CLINIC - RHC									15
16	HOSPITAL-BASED HEALTH CLINIC - FQHC									16
17	HOSPITAL-BASED (CMHC)									17
18	RENAL DIALYSIS									18
19	OTHER									19
20	COST REPORTING PERIOD (mm/dd/yyyy)		FROM: 01 / 01 / 2013		TO: 12 / 31 / 2013					
21	TYPE OF CONTROL (see instructions)		2							21
INPATIENT PPS INFORMATION										
22	DOES THIS FACILITY QUALIFY FOR AND RECEIVE DISPROPORTIONATE SHARE HOSPITAL PAYMENT IN ACCORDANCE WITH 42 CFR §412.106 IN COLUMN 1, ENTER 'Y' FOR YES AND 'N' FOR NO. IS THIS FACILITY SUBJECT TO 42 CFR§412.06(c)(2)(Pickle amendment hospital)? IN COLUMN 2, ENTER 'Y', FOR YES OR 'N' FOR NO.							N	N	22
22.01	DID THIS HOSPITAL RECEIVE INTERIM UNCOMPENSATED CARE PAYMENTS FOR THIS COST REPORTING PERIOD? ENTER IN COLUMN 1, 'Y' FOR YES OR 'N' FOR NO FOR THE PORTION OF THE COST REPORTING PERIOD OCCURRING PRIOR TO OCTOBER 1. ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO FOR THE PORTION OF THE COST REPORTING PERIOD OCCURRING ON OR AFTER OCTOBER 1. (see instructions)							N	N	22.01
23	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.								N	23
		IN-STATE MEDICAID PAID DAYS	IN-STATE MEDICAID ELIGIBLE UNPAID DAYS	OUT-OF- STATE MEDICAID PAID DAYS	OUT-OF- STATE MEDICAID ELIGIBLE UNPAID DAYS	MEDICAID HMO DAYS	OTHER MEDICAID DAYS			
		1	2	3	4	5	6			
24	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 COL. 5, AND OTHER MEDICAID DAYS IN COL. 6.	3,117							24	
25	IF THIS PROVIDER IS AN IRF, ENTER THE IN-STATE MEDICAID PAID DAYS IN COL. 1, 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.								25	
26	ENTER YOUR STANDARD GEOGRAPHIC CLASSIFICATION (not wage) STATUS AT THE BEGINNING OF THE COST REPORTING PERIOD. ENTER '1' FOR URBAN AND '2' FOR RURAL.			1						26
27	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
35	IF THIS IS A SOLE COMMUNITY HOSPITAL (SCH), ENTER THE NUMBER OF PERIODS SCH STATUS IN EFFECT IN THE COST REPORTING PERIOD.								35	
36	ENTER APPLICABLE BEGINNING AND ENDING DATES OF SCH STATUS. SUBSCRIPT LINE 36 FOR NUMBER OF PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.			BEGINNING:	ENDING:					
37	IF THIS IS A MEDICARE DEPENDENT HOSPITAL (MDH), ENTER THE NUMBER OF PERIODS MDH STATUS IN EFFECT IN THE COST REPORTING PERIOD.								37	
38	ENTER APPLICABLE BEGINNING AND ENDING DATES OF MDH STATUS. SUBSCRIPT LINE 38 FOR NUMBER PERIODS IN EXCESS OF ONE AND ENTER SUBSEQUENT DATES.			BEGINNING:	ENDING:					
							1	2		



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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

**WORKSHEET S-2
PART I**

39	DOES THIS FACILITY QUALIFY FOR THE INPATIENT HOSPITAL PAYMENT ADJUSTMENT FOR LOW VOLUME HOSPITALS IN ACCORDANCE WITH 42 CFR §412.101(b)(2)(ii)? ENTER IN COLUMN 1 'Y' FOR YES OR 'N' FOR NO. DOES THE FACILITY MEET THE MILEAGE REQUIREMENTS IN ACCORDANCE WITH 42 CFR 412.101(b)(2)(ii)? ENTER IN COLUMN 2 'Y' FOR YES OR 'N' FOR NO. (see instructions)	N	N	39
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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

		V	XVIII	XIX	
PROSPECTIVE PAYMENT SYSTEM (PPS)-CAPITAL		I	2	3	
45	DOES THIS FACILITY QUALIFY AND RECEIVE CAPITAL PAYMENT FOR DISPROPORTIONATE SHARE IN ACCORDANCE WITH 42 CFR §412.320?	N	Y	N	45
46	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
47	IS THIS A NEW HOSPITAL UNDER 42 CFR §412.300 PPS CAPITAL? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	N	N	47
48	IS THE FACILITY ELECTING FULL FEDERAL CAPITAL PAYMENT? ENTER 'Y' FOR YES OR 'N' FOR NO.	N	N	N	48
TEACHING HOSPITALS		I	2	3	
56	IS THIS A HOSPITAL INVOLVED IN TRAINING RESIDENTS IN APPROVED GME PROGRAMS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N			56
57	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.	N	N		57
58	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
59	ARE COSTS CLAIMED ON LINE 100 OF WORKSHEET A? IF YES, COMPLETE WORKSHEET D-2, PART I.	N			59
60	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
		Y/N	IME	DIRECT GME	
61	DID YOUR HOSPITAL RECEIVE FTE SLOTS UNDER ACA SECTION 5503? ENTER 'Y' FOR YES OR 'N' FOR NO IN COLUMN 1.(see instructions)	N			61
61.01	ENTER THE AVERAGE NUMBER OF UNWEIGHTED PRIMARY CARE FTEs FROM THE HOSPITAL'S 3 MOST RECENT COST REPORTS ENDING AND SUBMITTED BEFORE MARCH 23, 2010. (see instructions)				61.01
61.02	ENTER THE CURRENT YEAR TOTAL UNWEIGHTED PRIMARY CARE FTE COUNT (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503) of ACA). (see instructions)				61.02
61.03	ENTER THE BASE LINE FTE COUNT FOR PRIMARY CARE AND/OR GENERAL SURGERY RESIDENTS, WHICH IS USED FOR DETERMINING COMPLIANCE WITH THE 75% TEST. (see instructions)				61.03
61.04	ENTER THE NUMBER OF UNWEIGHTED PRIMARY CARE/OR SURGERY ALLOPATHIC AND/OR OSTEOPATHIC FTEs IN THE CURRENT COST REPORTING PERIOD. (see instructions)				61.04
61.05	ENTER THE DIFFERENCE BETWEEN THE BASELINE PRIMARY AND/OR GENERAL SURGERY FTEs AND THE CURRENT YEAR'S PRIMARY CARE AND/OR GENERAL SURGERY FTE COUNTS (line 61.04 minus line 61.03). (see instructions)				61.05
61.06	ENTER THE AMOUNT OF ACA §5503 AWARD THAT IS BEING USED FOR CAP RELIEF AND/OR FTEs THAT ARE NONPRIMARY CARE OR GENERAL SURGERY. (see instructions)				61.06
OF THE FTEs IN LINE 61.05, SPECIFY EACH NEW PROGRAM SPECIALTY, IF ANY, AND THE NUMBER OF FTE RESIDENTS FOR EACH NEW PROGRAM (see instructions). ENTER IN COLUMN 1 THE PROGRAM NAME, ENTER IN COLUMN 2 THE PROGRAM CODE, ENTER IN COLUMN 3 THE IME FTE UNWEIGHTED COUNT AND ENTER IN COLUMN 4 DIRECT GME FTE UNWEIGHTED COUNT.					
		PROGRAM NAME	PROGRAM CODE	UNWEIGHTED IME FTE COUNT	UNWEIGHTED DIRECT GME FTE COUNT
		1	2	3	4
OF THE FTEs IN LINE 61.05, SPECIFY EACH EXPANDED PROGRAM SPECIALTY, IF ANY, AND THE NUMBER OF FTE RESIDENTS FOR EACH EXPANDED PROGRAM (see instructions). ENTER IN COLUMN 1 THE PROGRAM NAME, ENTER IN COLUMN 2 THE PROGRAM CODE, ENTER IN COLUMN 3 THE IME FTE UNWEIGHTED COUNT AND ENTER IN COLUMN 4 DIRECT GME FTE UNWEIGHTED COUNT.					
ACA PROVISIONS AFFECTING THE HEALTH RESOURCES AND SERVICES ADMINISTRATION (HRSA)					
62	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)				62
62.01	ENTER THE NUMBER OF FTE RESIDENTS THAT ROTATED FROM A TEACHING HEALTH CENTER (THC) INTO YOUR HOSPITAL IN THIS COST REPORTING PERIOD OF HRSA THC PROGRAM. (see instructions)				62.01
TEACHING HOSPITALS THAT CLAIM RESIDENTS IN NON-PROVIDER SETTINGS					
63	HAS YOUR FACILITY TRAINED RESIDENTS IN NON-PROVIDER SETTINGS DURING THIS COST REPORTING PERIOD? ENTER 'Y' FOR YES OR 'N' FOR NO. IF YES, COMPLETE LINES 64-67. (see instructions)	N			63



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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

SECTION 5504 OF THE ACA BASE YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS-THIS BASE YEAR IS YOUR COST REPORTING PERIOD THAT BEGINS ON OR AFTER JULY 1, 2009 AND BEFORE JUNE 30, 2010.		UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (col. 1/ col. 1 + col. 2)		
64	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)				64	
ENTER IN LINES 65-65.49 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)						
	PROGRAM NAME	PROGRAM CODE	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (col. 3/ col. 3 + col. 4)	
	1	2	3	4	5	
65						65
SECTION 5504 OF THE ACA CURRENT YEAR FTE RESIDENTS IN NON-PROVIDER SETTINGS-EFFECTIVE FOR COST REPORTING PERIODS BEGINNING ON OR AFTER JULY 1, 2010		UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (col. 1/ col. 1 + col. 2)		
66	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)				66	
ENTER IN LINES 67-67.49, 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 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)						
	PROGRAM NAME	PROGRAM CODE	UNWEIGHTED FTEs NONPROVIDER SITE	UNWEIGHTED FTEs IN HOSPITAL	RATIO (col. 3/ col. 3 + col. 4)	
	1	2	3	4	5	
67						67
INPATIENT PSYCHIATRIC FACILITY PPS		1	2	3		
70	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	
71	IF LINE 70 YES: COLUMN 1: DID THE FACILITY HAVE A TEACHING PROGRAM IN THE MOST RECENT COST REPORT FILED ON OR BEFORE NOVEMBER 15, 2004? ENTER 'Y' FOR YES OR 'N' FOR NO. COLUMN 2: DID THIS FACILITY TRAIN RESIDENTS IN A NEW TEACHING PROGRAM IN ACCORDANCE WITH 42 CFR §412.424(d)(1)(iii)(D)? ENTER 'Y' FOR YES AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. 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.	N			71	
INPATIENT REHABILITATION FACILITY PPS		1	2	3		
75	IS THIS FACILITY AN INPATIENT REHABILITATION FACILITY (IRF), OR DOES IT CONTAIN AN IRF SUBPROVIDER? ENTER 'Y' FOR YES OR 'N' FOR NO.	N			75	
76	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 AND 'N' FOR NO. COLUMN 3: IF COLUMN 2 IS Y, ENTER 1, 2, OR 3 RESPECTIVELY IN COLUMN 3. 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.				76	
LONG TERM CARE HOSPITAL PPS						
80	IS THIS A LONG TERM CARE HOSPITAL (LTCH)? ENTER 'Y' FOR YES OR 'N' FOR NO.		N		80	
TEFRA PROVIDERS						
85	IS THIS A NEW HOSPITAL UNDER 42 CFR §413.40(f)(1)(i) TEFRA? ENTER 'Y' FOR YES OR 'N' FOR NO.		N		85	
86	DID THIS FACILITY ESTABLISH A NEW OTHER SUBPROVIDER (excluded unit) UNDER 42 CFR §413.40(f)(1)(ii)? ENTER 'Y' FOR YES, OR 'N' FOR NO.				86	



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**WORKSHEET S-2
PART I**

		V	XIX		
TITLE V AND XIX SERVICES		1	2		
90	DOES THIS FACILITY HAVE TITLE V AND/OR XIX INPATIENT HOSPITAL SERVICES? ENTER 'Y' FOR YES, OR 'N' FOR NO IN APPLICABLE COLUMN.	N	Y	90	
91	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	
92	ARE TITLE XIX NF PATIENTS OCCUPYING TITLE XVIII SNF BEDS (dual certification)? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.		N	92	
93	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	
94	DOES TITLE V OR TITLE XIX REDUCE CAPITAL COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.	N	N	94	
95	IF LINE 94 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.			95	
96	DOES TITLE V OR TITLE XIX REDUCE OPERATING COST? ENTER 'Y' FOR YES OR 'N' FOR NO IN THE APPLICABLE COLUMN.	N	N	96	
97	IF LINE 96 IS 'Y', ENTER THE REDUCTION PERCENTAGE IN THE APPLICABLE COLUMN.			97	
RURAL PROVIDERS		1	2		
105	DOES THIS HOSPITAL QUALIFY AS A CRITICAL ACCESS HOSPITAL (CAH)?	N		105	
106	IF THIS FACILITY QUALIFIES AS A CAH, HAS IT ELECTED THE ALL-INCLUSIVE METHOD OF PAYMENT FOR OUTPATIENT SERVICES.			106	
107	COLUMN 1: IF THIS FACILITY QUALIFIES AS A CAH, IS IT ELIGIBLE FOR COST REIMBURSEMENT FOR I&R TRAINING PROGRAMS? ENTER 'Y' FOR YES AND 'N' FOR NO IN COLUMN 1. IF YES, THE GME ELIMINATION WOULD NOT BE ON WORKSHEET B, PART I, COLUMN 26 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.			107	
108	IS THIS A RURAL HOSPITAL QUALIFYING FOR AN EXCEPTION TO THE CRNA FEE SCHEDULE? SEE 42 CFR §412.113(c). ENTER 'Y' FOR YES OR 'N' FOR NO.	N		108	
109	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 EACH THERAPY.	N		109	
		PHYSICAL	OCCUPATIONAL	SPEECH	RESPIRATORY
MISCELLANEOUS COST REPORTING INFORMATION					
115	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'	N			115
116	IS THIS FACILITY CLASSIFIED AS A REFERRAL CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO.	N			116
117	IS THIS FACILITY LEGALLY REQUIRED TO CARRY MALPRACTICE INSURANCE? ENTER 'Y' FOR YES OR 'N' FOR NO.	N			117
118	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.				118
		PREMIUMS	PAID LOSSES	SELF INSURANCE	
118.01	LIST AMOUNTS OF MALPRACTICE PREMIUMS AND PAID LOSSES:				118.01
118.02	ARE MALPRACTICE PREMIUMS AND PAID LOSSES REPORTED IN A COST CENTER OTHER THAN THE ADMINISTRATIVE AND GENERAL COST CENTER? IF YES, SUBMIT SUPPORTING SCHEDULE LISTING COST CENTERS AND AMOUNTS CONTAINED THEREIN.	N			118.02
120	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
121	DID THIS FACILITY INCUR AND REPORT COSTS FOR HIGH COST IMPLANTABLE DEVICES CHARGED TO PATIENTS? ENTER 'Y' FOR YES OR 'N' FOR NO.	Y			121
TRANSPLANT CENTER INFORMATION					
125	DOES THIS FACILITY OPERATE A TRANSPLANT CENTER? ENTER 'Y' FOR YES OR 'N' FOR NO. IF YES, ENTER CERTIFICATION DATE(S)(mm/dd/yyyy) BELOW.	N			125
126	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
127	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
128	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
129	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
130	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
131	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
132	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
133	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
134	IF THIS IS AN ORGAN PROCUREMENT ORGANIZATION (OPO), ENTER THE OPO NUMBER IN COLUMN 1 AND TERMINATION DATE, IF APPLICABLE, IN COLUMN 2.				134



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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

WORKSHEET S-2
PART I

ALL PROVIDERS							
		1	2				
140	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.	N				140	
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	NAME:	CONTRACTOR'S NAME:		CONTRACTOR'S NUMBER:		141	
142	STREET:	P.O. BOX:				142	
143	CITY:	STATE:	ZIP CODE:			143	
144	ARE PROVIDER BASED PHYSICIANS' COSTS INCLUDED IN WORKSHEET A?	Y				144	
145	IF COSTS FOR RENAL SERVICES ARE CLAIMED ON WORKSHEET A, LINE 74 ARE THEY COSTS FOR INPATIENT SERVICES ONLY? ENTER 'Y' FOR YES, OR 'N' FOR NO.	Y				145	
146	HAS THE COST ALLOCATION METHODOLOGY CHANGED FROM THE PREVIOUSLY FILED COST REPORT? ENTER 'Y' FOR YES AND '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	
147	WAS THERE A CHANGE IN THE STATISTICAL BASIS? ENTER 'Y' FOR YES OR 'N' FOR NO.	N				147	
148	WAS THERE A CHANGE IN THE ORDER OF ALLOCATION? ENTER 'Y' FOR YES OR 'N' FOR NO.	N				148	
149	WAS THERE A CHANGE TO THE SIMPLIFIED COST FINDING METHOD? ENTER 'Y' FOR YES OR 'N' FOR NO.	N				149	
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)							
		TITLE XVIII			TITLE V	TITLE XIX	
		PART A	PART B	1	2	3	
155	HOSPITAL	N	N	N		N	155
156	SUBPROVIDER - IPF	N	N	N		N	156
157	SUBPROVIDER - IRF	N	N	N			157
158	SUBPROVIDER - (OTHER)						158
159	SNF	N	N				159
160	HHA	N	N				160
161	CMHC		N				161
161.10	CORF						161.10
MULTICAMPUS							
165	IS THIS HOSPITAL PART OF A MULTICAMPUS HOSPITAL THAT HAS ONE OR MORE CAMPUSES IN DIFFERENT CBSAs? ENTER 'Y' FOR YES OR 'N' FOR NO.	N					165
166	IF LINE 165 IS YES, FOR EACH CAMPUS, ENTER THE NAME IN COLUMN 0, COUNTY IN COLUMN 1, STATE IN COLUMN 2, ZIP IN COLUMN 3, CBSA IN COLUMN 4, FTE/CAMPUS IN COLUMN 5.						166
	NAME	COUNTY	STATE	ZIP CODE	CBSA	FTE/CAMPUS	
	0	1	2	3	4	5	
HEALTH INFORMATION TECHNOLOGY (HIT) INCENTIVE IN THE AMERICAN RECOVERY AND REINVESTMENT ACT							
167	IS THIS PROVIDER A MEANINGFUL USER UNDER §1886(n)? ENTER 'Y' FOR YES OR 'N' FOR NO.	Y					167
168	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
169	IF THIS PROVIDER IS A MEANINGFUL USER (line 167 is 'Y') AND IS NOT A CAH (line 105 is 'N'), ENTER THE TRANSITIONAL FACTOR. (see instructions)	1.00					169
170	ENTER IN COLUMNS 1 AND 2 THE EHR BEGINNING DATE AND ENDING DATE FOR THE REPORTING PERIOD RESPECTIVELY (mm/dd/yyyy)	06/01/2013	09/15/2013				170



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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

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

		Y/N	DATE		
PROVIDER ORGANIZATION AND OPERATION		1	2		
1	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
		Y/N	DATE	V/I	
		1	2	3	
2	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
3	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)	N			3
FINANCIAL DATA AND REPORTS		Y/N	TYPE	DATE	
		1	2	3	
4	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
5	ARE THE COST REPORT TOTAL EXPENSES AND TOTAL REVENUES DIFFERENT FROM THOSE ON THE FILED FINANCIAL STATEMENTS? IF YES, SUBMIT RECONCILIATION.	Y			5
APPROVED EDUCATIONAL ACTIVITIES		Y/N		Y/N	
		1		2	
6	COLUMN 1: ARE COSTS CLAIMED FOR NURSING SCHOOL? COLUMN 2: IF YES, IS THE PROVIDER THE LEGAL OPERATOR OF THE PROGRAM?	N			6
7	ARE COSTS CLAIMED FOR ALLIED HEALTH PROGRAMS? IF YES, SEE INSTRUCTIONS.	N			7
8	WERE NURSING SCHOOL AND/OR ALLIED HEALTH PROGRAMS APPROVED AND/OR RENEWED DURING THE COST REPORTING PERIOD?	N			8
9	ARE COSTS CLAIMED FOR INTERN-RESIDENT PROGRAMS CLAIMED ON THE CURRENT COST REPORT? IF YES, SEE INSTRUCTIONS.	N			9
10	WAS AN INTERN-RESIDENT PROGRAM INITIATED OR RENEWED IN THE CURRENT COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.	N			10
11	ARE GME COSTS DIRECTLY ASSIGNED TO COST CENTERS OTHER THAN I & R IN AN APPROVED TEACHING PROGRAM ON WORKSHEET A? IF YES, SEE INSTRUCTIONS.	N			11
BAD DEBTS				Y/N	
12	IS THE PROVIDER SEEKING REIMBURSEMENT FOR BAD DEBTS? IF YES, SEE INSTRUCTIONS.			Y	12
13	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
14	IF LINE 12 IS YES, WERE PATIENT DEDUCTIBLES AND/OR CO-PAYMENTS WAIVED? IF YES, SEE INSTRUCTIONS.			N	14
BED COMPLEMENT					
15	DID TOTAL BEDS AVAILABLE CHANGE FROM THE PRIOR COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.			N	15
		PART A		PART B	
PS&R REPORT DATA		Y/N	DATE	Y/N	DATE
		1	2	3	4
16	WAS THE COST REPORT PREPARED USING THE PS&R REPORT ONLY? IF EITHER COLUMN 1 OR 3 IS YES, ENTER THE PAID-THROUGH DATE OF THE PS&R REPORT USED IN COLUMNS 2 AND 4. (see instructions)	N		N	
17	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	05/13/2014	Y	05/13/2014
18	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 THE COST REPORT? IF YES, SEE INSTRUCTIONS.	N		N	
19	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR CORRECTIONS OF OTHER PS&R REPORT INFORMATION? IF YES, SEE INSTRUCTIONS.	N		N	
20	IF LINE 16 OR 17 IS YES, WERE ADJUSTMENTS MADE TO PS&R REPORT DATA FOR OTHER? DESCRIBE THE OTHER ADJUSTMENTS:	N		N	
21	WAS THE COST REPORT PREPARED ONLY USING THE PROVIDER'S RECORDS? IF YES, SEE INSTRUCTIONS.	N		N	



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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX REIMBURSEMENT QUESTIONNAIRE

WORKSHEET S-2
PART II

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 COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)

CAPITAL RELATED COSTS			
22	HAVE ASSETS BEEN RELIEVED FOR MEDICARE PURPOSES? IF YES, SEE INSTRUCTIONS.		22
23	HAVE CHANGES OCCURRED IN THE MEDICARE DEPRECIATION EXPENSE DUE TO APPRAISALS MADE DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		23
24	WERE NEW LEASES AND/OR AMENDMENTS TO EXISTING LEASES ENTERED INTO DURING THIS COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		24
25	HAVE THERE BEEN NEW CAPITALIZED LEASES ENTERED INTO DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		25
26	WERE ASSETS SUBJECT TO SEC. 2314 OF DEFRA ACQUIRED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		26
27	HAS THE PROVIDER'S CAPITALIZED POLICY CHANGED DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		27
INTEREST EXPENSE			
28	WERE NEW LOANS, MORTGAGE AGREEMENTS OR LETTERS OF CREDIT ENTERED INTO DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		28
29	DID THE PROVIDER HAVE A FUNDED DEPRECIATION ACCOUNT AND/OR BOND FUNDS (debt service reserve fund) TREATED AS A FUNDED DEPRECIATION ACCOUNT? IF YES, SEE INSTRUCTIONS.		29
30	HAS EXISTING DEBT BEEN REPLACED PRIOR TO ITS SCHEDULED MATURITY WITH NEW DEBT? IF YES, SEE INSTRUCTIONS.		30
31	HAS DEBT BEEN RECALLED BEFORE SCHEDULED MATURITY WITHOUT ISSUANCE OF NEW DEBT? IF YES, SEE INSTRUCTIONS.		31
PURCHASED SERVICES			
32	HAVE CHANGES OR NEW AGREEMENTS OCCURRED IN PATIENT CARE SERVICES FURNISHED THROUGH CONTRACTUAL ARRANGEMENTS WITH SUPPLIERS OF SERVICES? IF YES, SEE INSTRUCTIONS.		32
33	IF LINE 32 IS YES, WERE THE REQUIREMENTS OF SEC. 2135.2 APPLIED PERTAINING TO COMPETITIVE BIDDING? IF NO, SEE INSTRUCTIONS.		33
PROVIDER-BASED PHYSICIANS			
34	ARE SERVICES FURNISHED AT THE PROVIDER FACILITY UNDER AN ARRANGEMENT WITH PROVIDER-BASED PHYSICIANS? IF YES, SEE INSTRUCTIONS.		34
35	IF LINE 34 IS YES, WERE THERE NEW AGREEMENTS OR AMENDED EXISTING AGREEMENTS WITH THE PROVIDER-BASED PHYSICIANS DURING THE COST REPORTING PERIOD? IF YES, SEE INSTRUCTIONS.		35
HOME OFFICE COSTS		Y/N	DATE
36	WERE HOME OFFICE COSTS CLAIMED ON THE COST REPORT?	1	2
37	IF LINE 36 IS YES, HAS A HOME OFFICE COST STATEMENT BEEN PREPARED BY THE HOME OFFICE? IF YES, SEE INSTRUCTIONS.		
38	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.		
39	IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO OTHER CHAIN COMPONENTS? IF YES, SEE INSTRUCTIONS.		
40	IF LINE 36 IS YES, DID THE PROVIDER RENDER SERVICES TO THE HOME OFFICE? IF YES, SEE INSTRUCTIONS.		
COST REORT PREPARER INFORMATION			
41	FIRST NAME: MICHAEL	LAST NAME: RAUWOLF	TITLE: DIRECTOR OF AUDIT
42	EMPLOYER: PALOS COMMUNITY HOSPITAL		
43	PHONE NUMBER: 708-923-4161	E-MAIL ADDRESS: MRAUWOLF@PALOSCOMM.ORG	



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HOSPITAL WAGE INDEX INFORMATION

WORKSHEET S-3
PARTS II-III

PART II - WAGE DATA

	WKST A LINE NO.	AMOUNT REPORTED	RECLASSIF- ICATION OF SALARIES (from Worksheet A-6)	ADJUSTED SALARIES (column 2 ± column 3)	PAID HOURS RELATED TO SALARIES IN COLUMN 4	AVERAGE HOURLY WAGE (column 4 ± column 5)	
	1	2	3	4	5	6	
SALARIES							
1	200	161,118,541		161,118,541	4,764,784.00	33.81	1
2							2
3							3
4							4
4.01							4.01
5		4,528,927		4,528,927	41,414.63	109.36	5
6							6
7	21						7
7.01							7.01
8							8
9	44						9
10		15,928,504		15,928,504	505,277.00	31.52	10
OTHER WAGES & RELATED COSTS							
11		192,073		192,073	4,832.00	39.75	11
12							12
13		636,656		636,656	5,816.05	109.47	13
14							14
15							15
16							16
WAGE-RELATED COSTS							
17		43,337,840		43,337,840			17
18							18
19		5,066,766		5,066,766			19
20							20
21							21
22							22
22.01							22.01
23		851,330		851,330			23
24							24
25							25
OVERHEAD COSTS - DIRECT SALARIES							
26		1,798,174		1,798,174	32,311.00	55.65	26
27		26,769,248		26,769,248	674,325.00	39.70	27
28		833,930		833,930	3,038.00	274.50	28
29		2,820,071		2,820,071	82,596.00	34.14	29
30							30
31		145,128		145,128	6,477.00	22.41	31
32		2,916,782		2,916,782	137,599.00	21.20	32
33							33
34		3,459,640	-1,324,310	2,135,330	92,274.00	23.14	34
35							35
36			1,324,310	1,324,310	57,652.00	22.97	36
37							37
38		2,327,967		2,327,967	54,617.00	42.62	38
39		2,233,502		2,233,502	95,945.00	23.28	39
40		4,562,239		4,562,239	107,587.00	42.41	40
41		2,907,081		2,907,081	109,665.00	26.51	41
42		904,941		904,941	27,521.00	32.88	42
43							43

PART III - HOSPITAL WAGE INDEX SUMMARY

1	NET SALARIES (see instructions)	157,423,544		157,423,544	4,726,407.37	33.31	1
2	EXCLUDED AREA SALARIES (see instructions)	15,928,504		15,928,504	505,277.00	31.52	2
3	SUBTOTAL SALARIES (line 1 minus line 2)	141,495,040		141,495,040	4,221,130.37	33.52	3
4	SUBTOTAL OTHER WAGES & RELATED COSTS (see instructions)	828,729		828,729	10,648.05	77.83	4
5	SUBTOTAL WAGE-RELATED COSTS (see instructions)	43,337,840		43,337,840		30.63%	5
6	TOTAL (sum of lines 3 through 5)	185,661,609		185,661,609	4,231,778.42	43.87	6
7	TOTAL OVERHEAD COST (see instructions)	51,678,703		51,678,703	1,481,607.00	34.88	7



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HOSPITAL WAGE RELATED COSTS

WORKSHEET S-3

PART IV - WAGE RELATED COST

PART IV

PART A - CORE LIST

		AMOUNT REPORTED	
	RETIREMENT COST		
1	401K EMPLOYER CONTRIBUTIONS	9,328,678	1
2	TAX SHELTERED ANNUITY (TSA) EMPLOYER CONTRIBUTION		2
3	NONQUALIFIED DEFINED BENEFIT PLAN COST (see instructions)		3
4	QUALIFIED DEFINED BENEFIT PLAN COST (see instructions)		4
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization):		
5	401k/TSA PLAN ADMINISTRATION FEES		5
6	LEGAL/ACCOUNTING/MANAGEMENT FEES-PENSION PLAN	22,182	6
7	EMPLOYEE MANAGED CARE PROGRAM ADMINISTRATION FEES		7
	HEALTH AND INSURANCE COST		
8	HEALTH INSURANCE (Purchased or Self Funded)	22,852,049	8
9	PRESCRIPTION DRUG PLAN		9
10	DENTAL, HEARING AND VISION PLAN	1,126,415	10
11	LIFE INSURANCE (If employee is owner or beneficiary)	392,942	11
12	ACCIDENTAL INSURANCE (If employee is owner or beneficiary)		12
13	DISABILITY INSURANCE (If employee is owner or beneficiary)	720,413	13
14	LONG-TERM CARE INSURANCE (If employee is owner or beneficiary)		14
15	WORKERS' COMPENSATION INSURANCE	3,246,818	15
16	RETIREMENT HEALTH CARE COST (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		16
	TAXES		
17	FICA-EMPLOYERS PORTION ONLY	11,330,909	17
18	MEDICARE TAXES - EMPLOYERS PORTION ONLY		18
19	UNEMPLOYMENT INSURANCE	117,873	19
20	STATE OR FEDERAL UNEMPLOYMENT TAXES		20
	OTHER		
21	EXECUTIVE DEFERRED COMPENSATION (Other Than Retirement Cost Reported on lines 1 through 4 above)(see instructions)		21
22	DAY CARE COSTS AND ALLOWANCES		22
23	TUITION REIMBURSEMENT	117,653	23
24	TOTAL WAGE RELATED COST (Sum of lines 1-23)	49,255,932	24

PART B - OTHER THAN CORE RELATED COST

25	OTHER WAGE RELATED (OTHER WAGE REL		25
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WAGE INDEX PENSION COST SCHEDULE (For Worksheet S-3, Part IV, Line 4)

EXHIBIT 3

STEP 2: DETERMINE THE 3-YEAR AVERAGING PERIOD			
1	WAGE INDEX FISCAL YEAR ENDING DATE		1
2	PROVIDER'S COST REPORTING PERIOD USED FOR WAGE INDEX YEAR ON LINE 1 (FYB in Col. 1, FYE in Col. 2)		2
3	MIDPOINT OF PROVIDER'S COST REPORTING PERIOD SHOWN ON LINE 2, ADJUSTED TO FIRST OF MONTH		3
4	DATE BEGINNING THE 3-YEAR AVERAGING PERIOD (subtract 18 months from midpoint shown on Line 3)		4
5	DATE ENDING THE 3-YEAR AVERAGING PERIOD (add 18 months to midpoint shown on Line 3)		5
STEP 2 (OPTIONAL): ADJUST AVERAGING PERIOD FOR A NEW PLAN (see instructions)			
6	EFFECTIVE DATE OF PENSION PLAN		6
7	FIRST DAY OF THE PROVIDER COST REPORTING PERIOD CONTAINING THE PENSION PLAN EFFECTIVE DATE		7
8	STARTING DATE OF THE ADJUSTED AVERAGING PERIOD (date on Line 7, adjusted to first of month)		8

IF THIS DATE OCCURS AFTER THE PERIOD SHOWN ON LINE 2, STOP HERE AND SEE INSTRUCTIONS

STEP 3: AVERAGE PENSION CONTRIBUTIONS DURING THE AVERAGING PERIOD			
9	BEGINNING DATE OF AVERAGING PERIOD FROM LINE 4 OR LINE 8, AS APPLICABLE		9
10	ENDING DATE OF AVERAGING PERIOD FROM LINE 5		10
11	ENTER PROVIDER CONTRIBUTIONS MADE DURING AVERAGING PERIOD ON LINES 9 & 10	DEPOSIT DATE(S)	CONTRIB-UTION(S) 11
12	TOTAL CALENDAR MONTHS INCLUDED IN AVERAGING PERIOD (36 unless Step 2 completed)		12
13	TOTAL CONTRIBUTIONS MADE DURING AVERAGING PERIOD		13
14	AVERAGE MONTHLY CONTRIBUTION (Line 13 divided by Line 12)		14
15	NUMBER OF MONTHS IN PROVIDER COST REPORTING PERIOD ON LINE 2		15
16	AVERAGE PENSION CONTRIBUTIONS (Line 14 times Line 15)		16
STEP 4: TOTAL PENSION COST FOR WAGE INDEX			
17	ANNUAL PREFUNDING INSTALLMENT (see instructions)		17
18	REPORTABLE PREFUNDING INSTALLMENT ((Line 17 times Line 15) divided by 12)		18
19	TOTAL PENSION COST FOR WAGE INDEX (Line 16 plus Line 18 - transfers to S-3 Part IV Line 4)		19



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HOSPITAL CONTRACT LABOR AND BENEFIT COST

**WORKSHEET S-3
PART V**

PART V - CONTRACT LABOR AND BENEFIT COST

HOSPITAL AND HOSPITAL-BASED COMPONENT IDENTIFICATION:

	COMPONENT	CONTRACT LABOR	BENEFIT COST	
	0	1	2	
1	TOTAL FACILITY CONTRACT LABOR AND BENEFIT COST	1,055,660		1
2	HOSPITAL	192,073		2
3	SUBPROVIDER - IPF			3
4	SUBPROVIDER - IRF			4
5	SUBPROVIDER - (OTHER)			5
6	SWING BEDS - SNF			6
7	SWING BEDS - NF			7
8	HOSPITAL-BASED SNF			8
9	HOSPITAL-BASED NF			9
10	HOSPITAL-BASED OLTC			10
11	HOSPITAL-BASED HHA	863,207		11
12	SEPARATELY CERTIFIED ASC			12
13	HOSPITAL-BASED HOSPICE	380		13
14	HOSPITAL-BASED HEALTH CLINIC - RHC			14
15	HOSPITAL-BASED HEALTH CLINIC - FQHC			15
16	HOSPITAL-BASED (CMHC)			16
17	RENAL DIALYSIS			17
18	OTHER			18



COMPU-MAX

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HOSPITAL-BASED HOME HEALTH AGENCY STATISTICAL DATA

HHA CCN: 14-7470

WORKSHEET S-4

HOME HEALTH AGENCY STATISTICAL DATA

COUNTY:

	DESCRIPTION	TITLE V 1	TITLE XVIII 2	TITLE XIX 3	OTHER 4	TOTAL 5	
1	HOME HEALTH AIDE HOURS		10,527		1,474	12,001	1
2	UNDUPLICATED CENSUS COUNT (see instructions)		2,542.00	28.00	782.00	3,352.00	2

HOME HEALTH AGENCY - NUMBER OF EMPLOYEES

	ENTER THE NUMBER OF HOURS IN YOUR NORMAL WORK WEEK	NUMBER OF EMPLOYEES (Full Time Equivalent)				
		STAFF	CONTRACT	TOTAL		
		1	2	3		
3	ADMINISTRATOR AND ASSISTANT ADMINISTRATOR(S)				3	
4	DIRECTOR(S) AND ASSISTANT DIRECTOR(S)		0.81		0.81	4
5	OTHER ADMINISTRATIVE PERSONNEL		33.77		33.77	5
6	DIRECT NURSING SERVICE		46.89		46.89	6
7	NURSING SUPERVISOR		2.39		2.39	7
8	PHYSICAL THERAPY SERVICE		10.56	4.13	14.69	8
9	PHYSICAL THERAPY SUPERVISOR		1.35		1.35	9
10	OCCUPATIONAL THERAPY SERVICE		2.02	0.54	2.56	10
11	OCCUPATIONAL THERAPY SUPERVISOR		0.33		0.33	11
12	SPEECH PATHOLOGY SERVICE		0.33	0.28	0.61	12
13	SPEECH PATHOLOGY SUPERVISOR		0.33		0.33	13
14	MEDICAL SOCIAL SERVICE		1.19		1.19	14
15	MEDICAL SOCIAL SERVICE SUPERVISOR					15
16	HOME HEALTH AIDE		13.43		13.43	16
17	HOME HEALTH AIDE SUPERVISOR					17
18	REGISTERED DIETICIAN		0.77		0.77	18

HOME HEALTH AGENCY - CBSA CODES

19	ENTER IN COLUMN 1 THE NUMBER OF CBSAs WHERE YOU PROVIDED SERVICES DURING THE COST REPORTING PERIOD.		1	19
20	LIST THOSE CBSA CODE(S) IN COLUMN 1 SERVICED DURING THIS COST REPORTING PERIOD (line 20 contains the first code).		16974	20

PPS ACTIVITY

		FULL EPISODES				TOTAL (columns 1 through 4)	
		WITHOUT OUTLIERS	WITH OUTLIERS	LUPA EPISODES	PEP ONLY EPISODES		
		1	2	3	4		
21	SKILLED NURSING VISITS	33,162	4,488	1,078	520	39,248	21
22	SKILLED NURSING VISIT CHARGES	5,735,373	804,974	167,356	87,466	6,795,169	22
23	PHYSICAL THERAPY VISITS	15,680	822	166	312	16,980	23
24	PHYSICAL THERAPY VISIT CHARGES	3,029,911	159,900	28,080	60,060	3,277,951	24
25	OCCUPATIONAL THERAPY VISITS	2,667	194	8	67	2,936	25
26	OCCUPATIONAL THERAPY VISIT CHARGES	519,285	37,830	1,560	13,065	571,740	26
27	SPEECH PATHOLOGY VISITS	621	123	14	15	773	27
28	SPEECH PATHOLOGY VISIT CHARGES	121,095	23,985	2,535	2,925	150,540	28
29	MEDICAL SOCIAL SERVICE VISITS	493	74	8	9	584	29
30	MEDICAL SOCIAL SERVICE VISIT CHARGES	139,650	20,805	1,995	2,565	165,015	30
31	HOME HEALTH AIDE VISITS	8,448	1,935	23	121	10,527	31
32	HOME HEALTH AIDE VISIT CHARGES	896,982	206,296	2,354	12,947	1,118,579	32
33	TOTAL VISITS (sum of lines 21, 23, 25, 27, 29, and 31)	61,071	7,636	1,297	1,044	71,048	33
34	OTHER CHARGES						34
35	TOTAL CHARGES (sum of lines 22, 24, 26, 28, 30, 32 and 34)	10,442,296	1,253,790	203,880	179,028	12,078,994	35
36	TOTAL NUMBER OF EPISODES (standard/non-outlier)	3,244		394	71	3,709	36
37	TOTAL NUMBER OF OUTLIER EPISODES		165		8	173	37
38	TOTAL NON-ROUTINE MEDICAL SUPPLY CHARGES	173,475	98,100	7,892	1,668	281,135	38



COMPU-MAX

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HOSPICE IDENTIFICATION DATA

HOSPICE CCN: 14-1591

WORKSHEET S-9
PARTS I & II

PART I - ENROLLMENT DAYS

		UNDUPLICATED DAYS					TOTAL (sum of cols. 1, 2, & 5)	
		TITLE XVIII	TITLE XIX	TITLE XVIII SKILLED NURSING FACILITY	TITLE XIX NURSING FACILITY	ALL OTHER		
		1	2	3	4	5		
1	CONTINUOUS HOME CARE			2				1
2	ROUTINE HOME CARE	34,798	46	8,145	7	1,850	36,694	2
3	INPATIENT RESPITE CARE	168		168		2	170	3
4	GENERAL INPATIENT CARE	761	10	4		105	876	4
5	TOTAL HOSPICE DAYS	35,727	56	8,319	7	1,957	37,740	5

PART II - CENSUS DATA

		TITLE XVIII	TITLE XIX	TITLE XVIII SKILLED NURSING FACILITY	TITLE XIX NURSING FACILITY	ALL OTHER	TOTAL (sum of cols. 1, 2, & 5)	
		1	2	3	4	5	6	
		6	NUMBER OF PATIENTS RECEIVING HOSPICE CARE	714	7			
7	TOTAL NUMBER OF UNDUPLICATED CONTINUOUS C							7
8	AVERAGE LENGTH OF STAY (line 5/line 6)	50.04	8.00			31.56	48.20	8
9	UNDUPLICATED CENSUS COUNT	723	8			63	794	9

NOTE: Parts I & II, columns 1 and 2 also include the days reported in column 3 and 4.



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HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA

WORKSHEET S-10

UNCOMPENSATED AND INDIGENT CARE COST COMPUTATION

1	COST TO CHARGE RATIO (Worksheet C, Part I, line 202, column 3 divided by line 202, column 8)	0.240173	1
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MEDICAID (see instructions for each line)

2	NET REVENUE FROM MEDICAID	6,796,744	2
3	DID YOU RECEIVE DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?	N	3
4	IF LINE 3 IS YES, DOES LINE 2 INCLUDE ALL DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID?		4
5	IF LINE 4 IS NO, ENTER DSH OR SUPPLEMENTAL PAYMENTS FROM MEDICAID		5
6	MEDICAID CHARGES	65,505,518	6
7	MEDICAID COST (line 1 times line 6)	15,732,657	7
8	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR MEDICAID PROGRAM (line 7 minus the sum of lines 2 and 5) IF LINE 7 IS LESS THAN THE SUM OF LINES 2 AND 5, THEN ENTER ZERO.	8,935,913	8

STATE CHILDREN'S HEALTH INSURANCE PROGRAM (SCHIP)(see instructions for each line)

9	NET REVENUE FROM STAND-ALONE SCHIP		9
10	STAND-ALONE SCHIP CHARGES		10
11	STAND-ALONE SCHIP COST (line 1 times line 10)		11
12	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STAND-ALONE SCHIP (line 11 minus line 9) IF LINE 11 IS LESS THAN LINE 9, THEN ENTER ZERO.		12

OTHER STATE OR LOCAL GOVERNMENT INDIGENT CARE PROGRAM (see instructions for each line)

13	NET REVENUE FROM STATE OR LOCAL INDIGENT CARE PROGRAM (not included on lines 2, 5, or 9)		13
14	CHARGES FOR PATIENTS COVERED UNDER STATE OR LOCAL INDIGENT CARE PROGRAM (not included in lines 6 or 10)		14
15	STATE OR LOCAL INDIGENT CARE PROGRAM COST (line 1 times line 14)		15
16	DIFFERENCE BETWEEN NET REVENUE AND COSTS FOR STATE OR LOCAL INDIGENT CARE PROGRAM (line 15 minus line 13) IF LINE 15 IS LESS THAN LINE 13, THEN ENTER ZERO.		16

UNCOMPENSATED AND INDIGENT CARE COST COMPUTATION

17	PRIVATE GRANTS, DONATIONS, OR ENDOWMENT INCOME RESTRICTED TO FUNDING CHARITY CARE		17		
18	GOVERNMENT GRANTS, APPROPRIATIONS OF TRANSFERS FOR SUPPORT OF HOSPITAL OPERATIONS		18		
19	TOTAL UNREIMBURSED COST FOR MEDICAID, SCHIP AND STATE AND LOCAL INDIGENT CARE PROGRAMS (sum of lines 8, 12 and 16)	8,935,913	19		
		UNINSURED PATIENTS	INSURED PATIENTS	TOTAL (col. 1 + col. 2)	
		1	2	3	
20	TOTAL INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (at full charges excluding non-reimbursable cost centers) FOR THE ENTIRE FACILITY	22,983,482	2,045,629	25,029,111	20
21	COST OF INITIAL OBLIGATION OF PATIENTS APPROVED FOR CHARITY CARE (line 1 times line 20)	5,520,012	491,305	6,011,317	21
22	PARTIAL PAYMENT BY PATIENTS APPROVED FOR CHARITY CARE	86,108	86,764	172,872	22
23	COST OF CHARITY CARE (line 21 minus line 22)	5,433,904	404,541	5,838,445	23

24	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
25	IF LINE 24 IS YES, ENTER CHARGES FOR PATIENT DAYS BEYOND AN INDIGENT CARE PROGRAM'S LENGTH OF STAY LIMIT (see instructions)		25
26	TOTAL BAD DEBT EXPENSE FOR THE ENTIRE HOSPITAL COMPLEX (see instructions)	16,879,826	26
27	MEDICARE BAD DEBTS FOR THE ENTIRE HOSPITAL COMPLEX (see instructions)	789,951	27
28	NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (line 26 minus line 27)	16,089,875	28
29	COST OF NON-MEDICARE AND NON-REIMBURSABLE MEDICARE BAD DEBT EXPENSE (line 1 times line 28)	3,864,354	29
30	COST OF UNCOMPENSATED CARE (line 23, column 3 plus line 29)	9,702,799	30
31	TOTAL UNREIMBURSED AND UNCOMPENSATED CARE COST (line 19 plus line 30)	18,638,712	31



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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI- FICATIONS	RECLASSI- FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST- MENTS	NET EXPENSES FOR ALLOC- ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
GENERAL SERVICE COST CENTERS										
1	00100	CAP REL COSTS-BLDG & FIXT		8,169,739	8,169,739	12,206,796	20,376,535	-12,128,619	8,247,916	1
2	00200	CAP REL COSTS-MVBLE EQUIP		12,553,263	12,553,263		12,553,263	-97,544	12,455,719	2
3	00300	OTHER CAP REL COSTS							-0-	3
4	00400	EMPLOYEE BENEFITS DEPARTMENT	1,798,174	49,367,491	51,165,665		51,165,665	-302,554	50,863,111	4
5.01	00540	COMMUNICATIONS	469,088	332,944	802,032		802,032	-91,908	710,124	5.01
5.02	00550	DATA PROCESSING	3,565,451	3,557,240	7,122,691		7,122,691	-212,400	6,910,291	5.02
5.03	00560	PURCHASING & STORES	579,677	23,491	603,168		603,168	-15,600	587,568	5.03
5.04	00570	ADMITTING	2,463,152	53,271	2,516,423		2,516,423		2,516,423	5.04
5.05	00580	CASHIERING	2,344,891	1,465,722	3,810,613		3,810,613	-337,200	3,473,413	5.05
5.06	00590	ADMINISTRATIVE & GENERAL	17,346,989	23,711,406	41,058,395	-379,007	40,679,388	-19,836,870	20,842,518	5.06
6	00600	MAINTENANCE & REPAIRS	2,259,742	4,010,295	6,270,037		6,270,037	-11,297	6,258,740	6
6.01	00601	CLINICAL ENGINEERING	560,329	130,794	691,123		691,123		691,123	6.01
7	00700	OPERATION OF PLANT								7
8	00800	LAUNDRY & LINEN SERVICE	145,128	1,280,843	1,425,971		1,425,971		1,425,971	8
9	00900	HOUSEKEEPING	2,916,782	801,883	3,718,665		3,718,665		3,718,665	9
10	01000	DIETARY	3,459,640	1,784,841	5,244,481	-1,997,152	3,247,329	-110,021	3,137,308	10
11	01100	CAFETERIA				2,007,526	2,007,526	-1,027,196	980,330	11
12	01200	MAINTENANCE OF PERSONNEL								12
13	01300	NURSING ADMINISTRATION	2,327,967	52,191	2,380,158		2,380,158	-41,162	2,338,996	13
14	01400	CENTRAL SERVICES & SUPPLY	2,233,502	4,669,674	6,903,176	-3,540,720	3,362,456		3,362,456	14
15	01500	PHARMACY	4,562,239	9,812,741	14,374,980	-9,605,477	4,769,503		4,769,503	15
16	01600	MEDICAL RECORDS & LIBRARY	2,907,081	659,752	3,566,833		3,566,833	-77,302	3,489,531	16
17	01700	SOCIAL SERVICE	904,941	54,929	959,870		959,870		959,870	17
19	01900	NONPHYSICIAN ANESTHETISTS								19
20	02000	NURSING SCHOOL								20
21	02100	I&R SERVICES-SALARY & FRINGES APPRVD								21
22	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD								22
23	02300	PARAMED ED PRGM-PHARMACY RESIDENCY	76,951	10,748	87,699		87,699		87,699	23
INPATIENT ROUTINE SERV COST CENTERS										
30	03000	ADULTS & PEDIATRICS	37,087,540	1,544,948	38,632,488	346,789	38,979,277	-330,549	38,648,728	30
31	03100	INTENSIVE CARE UNIT	5,893,068	235,360	6,128,428		6,128,428	-1,983	6,126,445	31
40	04000	SUBPROVIDER - IPF	4,398,067	105,658	4,503,725		4,503,725	-50,000	4,453,725	40
43	04300	NURSERY								43
ANCILLARY SERVICE COST CENTERS										
50	05000	OPERATING ROOM	8,962,469	10,596,959	19,559,428	84,771	19,644,199	-1,115,414	18,528,785	50
51	05100	RECOVERY ROOM	1,441,143	36,011	1,477,154		1,477,154		1,477,154	51
53	05300	ANESTHESIOLOGY		748,866	748,866		748,866	-281,807	467,059	53
54	05400	RADIOLOGY-DIAGNOSTIC	5,860,442	3,096,127	8,956,569	65,465	9,022,034		9,022,034	54
54.01	03630	ULTRASOUND	1,287,537	175,885	1,463,422		1,463,422		1,463,422	54.01
57	05700	CT SCAN	1,272,017	787,472	2,059,489		2,059,489		2,059,489	57
58	05800	MRI	399,385	254,316	653,701		653,701		653,701	58
59	05900	CARDIAC CATHETERIZATION	1,890,320	1,765,206	3,655,526	-601,102	3,054,424	-14,777	3,039,647	59
60	06000	LABORATORY	5,773,748	4,870,636	10,644,384	16,106	10,660,490		10,660,490	60
62.30	06250	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	06300	BLOOD STORING, PROCESSING & TRANS.	507,467	2,036,883	2,544,350		2,544,350		2,544,350	63
64	06400	INTRAVENOUS THERAPY	1,378,647	151,079	1,529,726		1,529,726		1,529,726	64
65	06500	RESPIRATORY THERAPY	2,545,616	584,887	3,130,503		3,130,503	-22,408	3,108,095	65
66	06600	PHYSICAL THERAPY	4,442,974	537,098	4,980,072	59,029	5,039,101	-66,781	4,972,320	66
68	06800	SPEECH PATHOLOGY	244,005	3,544	247,549		247,549		247,549	68
69	06900	ELECTROCARDIOLOGY	1,703,735	192,067	1,895,802	84,771	1,980,573		1,980,573	69
70	07000	ELECTROENCEPHALOGRAPHY	109,613	209,907	319,520		319,520	-12,000	307,520	70
70.01	03290	EMG	154,338	12,247	166,585		166,585		166,585	70.01
70.03	03030	ANGIOGRAPHY	631,037	401,467	1,032,504		1,032,504		1,032,504	70.03
71	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS				3,540,720	3,540,720		3,540,720	71
72	07200	IMPL. DEV. CHARGED TO PATIENTS		12,543,993	12,543,993		12,543,993		12,543,993	72
73	07300	DRUGS CHARGED TO PATIENTS				9,605,477	9,605,477		9,605,477	73
74	07400	RENAL DIALYSIS		417,714	417,714		417,714		417,714	74
76.97	07697	CARDIAC REHABILITATION	779,572	38,169	817,741	149,823	967,564	-1,213	966,351	76.97
76.98	07698	HYPERBARIC OXYGEN THERAPY								76.98
76.99	07699	LITHOTRIPSY								76.99
OUTPATIENT SERVICE COST CENTERS										
90.01	09001	OUTPATIENT PSYCHE SERVICES	1,125,183	15,087	1,140,270	61,878	1,202,148		1,202,148	90.01
91	09100	EMERGENCY	6,611,805	565,014	7,176,819		7,176,819		7,176,819	91
91.01	09101	PCC	4,243,603	1,863,798	6,107,401	-627,951	5,479,450	-2,296,497	3,182,953	91.01
92	09200	OBSERVATION BEDS (NON-DISTINCT PART)								92
OTHER REIMBURSABLE COST CENTERS										
101	10100	HOME HEALTH AGENCY	7,865,279	1,884,339	9,749,618	8,333	9,757,951	-1,353	9,756,598	101
SPECIAL PURPOSE COST CENTERS										
113	11300	INTEREST EXPENSE		12,094,949	12,094,949	-12,094,949				113
116	11600	HOSPICE	2,515,535	1,202,897	3,718,432	2,223	3,720,655	-189	3,720,466	116
118		SUBTOTALS (sum of lines 1-117)	160,045,869	181,475,841	341,521,710	-606,651	340,915,059	-38,484,644	302,430,415	118
192	19200	PHYSICIANS' PRIVATE OFFICES		100,142	100,142	606,096	706,238	-100,142	606,096	192



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RECLASSIFICATION AND ADJUSTMENT OF TRIAL BALANCE OF EXPENSES

WORKSHEET A

		COST CENTER DESCRIPTIONS	SALARIES	OTHER	TOTAL (col. 1 + col. 2)	RECLASSI- FICATIONS	RECLASSI- FIED TRIAL BALANCE (col. 3 ± col. 4)	ADJUST- MENTS	NET EXPENSES FOR ALLOC- ATION (col. 5 ± col. 6)	
			1	2	3	4	5	6	7	
194	07950	NEW DIRECTION								194
194.01	07951	PRIVATE DUTY NURSING	914,208	23,809	938,017	555	938,572		938,572	194.01
194.02	07952	PHYSICIAN REFERRAL CENTER	69,719	196	69,915		69,915		69,915	194.02
200		TOTAL (sum of lines 118-199)	161,118,541	181,764,717	342,883,258		342,883,258	-38,584,786	304,298,472	200



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RECLASSIFICATIONS

WORKSHEET A-6

		INCREASES					
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	
		1	2	3	4	5	
1	INTEREST	A	CAP REL COSTS-BLDG & FIXT	1		12,094,949	1
500	TOTAL RECLASSIFICATIONS					12,094,949	500
	CODE LETTER - A						
1	CHARGEABLE SUPPLIES	B	MEDICAL SUPPLIES CHARGED TO P	71		3,540,720	1
500	TOTAL RECLASSIFICATIONS					3,540,720	500
	CODE LETTER - B						
1	SHARED NFS COST	C	CAFETERIA	11	1,324,310	683,216	1
500	TOTAL RECLASSIFICATIONS				1,324,310	683,216	500
	CODE LETTER - C						
1	PCC DEPRECIATION	D	LABORATORY	60		3,144	1
2			RADIOLOGY-DIAGNOSTIC	54		12,778	2
3			PHYSICAL THERAPY	66		11,522	3
4			CARDIAC REHABILITATION	76.97		12,698	4
5			PCC	91.01		65,198	5
6			PHYSICIANS' PRIVATE OFFICES	192		118,304	6
7			DIETARY	10		2,025	7
8			OUTPATIENT PSYCHE SERVICES	90.01		12,078	8
500	TOTAL RECLASSIFICATIONS					237,747	500
	CODE LETTER - D						
1	PCC OPERATING EXPENSES	E	LABORATORY	60		12,720	1
2			RADIOLOGY-DIAGNOSTIC	54		51,703	2
3			PHYSICAL THERAPY	66		46,620	3
4			CARDIAC REHABILITATION	76.97		51,377	4
5			PCC	91.01		263,806	5
6			PHYSICIANS' PRIVATE OFFICES	192		478,685	6
7			DIETARY	10		8,193	7
8			OUTPATIENT PSYCHE SERVICES	90.01		48,870	8
500	TOTAL RECLASSIFICATIONS					961,974	500
	CODE LETTER - E						
1	INSURANCE EXPENSE	F	CAP REL COSTS-BLDG & FIXT	1		379,007	1
500	TOTAL RECLASSIFICATIONS					379,007	500
	CODE LETTER - F						
1	PCC/LEMONT BUILDING INSURANCE	G	LABORATORY	60		242	1
2			RADIOLOGY-DIAGNOSTIC	54		984	2
3			PHYSICAL THERAPY	66		887	3
4			CARDIAC REHABILITATION	76.97		977	4
5			PCC	91.01		5,019	5
6			PHYSICIANS' PRIVATE OFFICES	192		9,107	6
7			DIETARY	10		156	7
8			OUTPATIENT PSYCHE SERVICES	90.01		930	8
9			HOME HEALTH AGENCY	101		966	9
10			HOSPICE	116		258	10
11			PRIVATE DUTY NURSING	194.01		64	11
500	TOTAL RECLASSIFICATIONS					19,590	500
	CODE LETTER - G						
1	CHARGEABLE DRUGS	H	DRUGS CHARGED TO PATIENTS	73		9,605,477	1
500	TOTAL RECLASSIFICATIONS					9,605,477	500
	CODE LETTER - H						
1	HHA DEPRECIATION	I	HOME HEALTH AGENCY	101		7,367	1
2			HOSPICE	116		1,965	2
3			PRIVATE DUTY NURSING	194.01		491	3
500	TOTAL RECLASSIFICATIONS					9,823	500
	CODE LETTER - I						
1	ALLOCATE CV ADMINISTRATION	J	ADULTS & PEDIATRICS	30	286,302	60,487	1
2			OPERATING ROOM	50	69,985	14,786	2
3			CARDIAC CATHETERIZATION	59	139,970	29,571	3
4			ELECTROCARDIOLOGY	69	69,985	14,786	4
5			CARDIAC REHABILITATION	76.97	69,985	14,786	5
500	TOTAL RECLASSIFICATIONS				636,227	134,416	500
	CODE LETTER - J						
	GRAND TOTAL (INCREASES)				1,960,537	27,666,919	

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.
 Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.



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RECLASSIFICATIONS

WORKSHEET A-6

		DECREASES						
	EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	COST CENTER	LINE #	SALARY	OTHER	WKST A-7 REF.	
		1	6	7	8	9	10	
1	INTEREST	A	INTEREST EXPENSE	113		12,094,949	11	1
500	TOTAL RECLASSIFICATIONS					12,094,949		500
	CODE LETTER - A							
1	CHARGEABLE SUPPLIES	B	CENTRAL SERVICES & SUPPLY	14		3,540,720		1
500	TOTAL RECLASSIFICATIONS					3,540,720		500
	CODE LETTER - B							
1	SHARED NFS COST	C	DIETARY	10	1,324,310	683,216		1
500	TOTAL RECLASSIFICATIONS				1,324,310	683,216		500
	CODE LETTER - C							
1	PCC DEPRECIATION	D	CAP REL COSTS-BLDG & FIXT	1		237,747	9	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
500	TOTAL RECLASSIFICATIONS					237,747		500
	CODE LETTER - D							
1	PCC OPERATING EXPENSES	E	PCC	91.01		961,974		1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
500	TOTAL RECLASSIFICATIONS					961,974		500
	CODE LETTER - E							
1	INSURANCE EXPENSE	F	ADMINISTRATIVE & GENERAL	5.06		379,007	12	1
500	TOTAL RECLASSIFICATIONS					379,007		500
	CODE LETTER - F							
1	PCC/LEMONT BUILDING INSURANCE	G	CAP REL COSTS-BLDG & FIXT	1		19,590	12	1
2								2
3								3
4								4
5								5
6								6
7								7
8								8
9								9
10								10
11								11
500	TOTAL RECLASSIFICATIONS					19,590		500
	CODE LETTER - G							
1	CHARGEABLE DRUGS	H	PHARMACY	15		9,605,477		1
500	TOTAL RECLASSIFICATIONS					9,605,477		500
	CODE LETTER - H							
1	HHA DEPRECIATION	I	CAP REL COSTS-BLDG & FIXT	1		9,823	9	1
2								2
3								3
500	TOTAL RECLASSIFICATIONS					9,823		500
	CODE LETTER - I							
1	ALLOCATE CV ADMINISTRATION	J	CARDIAC CATHETERIZATION	59	636,227	134,416		1
2								2
3								3
4								4
5								5
500	TOTAL RECLASSIFICATIONS				636,227	134,416		500
	CODE LETTER - J							
	GRAND TOTAL (DECREASES)				1,960,537	27,666,919		

(1) A letter (A, B, etc.) must be entered on each line to identify each reclassification entry.
 Transfer the amounts in columns 4, 5, 8, and 9 to Worksheet A, column 4, lines as appropriate.



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RECLASSIFICATIONS

WORKSHEET A-6

EXPLANATION OF RECLASSIFICATION(S)	CODE (1)	DECREASES				WKST A-7 REF.
		COST CENTER	LINE #	SALARY	OTHER	
	1	6	7	8	9	10



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RECONCILIATION OF CAPITAL COST CENTERS

WORKSHEET A-7
PARTS I, II & III

PART I - ANALYSIS OF CHANGES IN CAPITAL ASSETS BALANCES

	DESCRIPTION	BEGINNING BALANCES	ACQUISITIONS			DISPOSALS AND RETIRE- MENTS	ENDING BALANCE	FULLY DEPREC- IATED ASSETS	
			PURCHASES	DONATION	TOTAL				
		1	2	3	4	5	6	7	
1	LAND	7,365,265					7,365,265		1
2	LAND IMPROVEMENTS	6,547,027	364,280		364,280		6,911,307	3,107,413	2
3	BUILDINGS AND FIXTURES	202,341,589	191,786,639		191,786,639		394,128,228	43,756,118	3
4	BUILDING IMPROVEMENTS								4
5	FIXED EQUIPMENT	199,116,371				73,183,180	125,933,191		5
6	MOVABLE EQUIPMENT	157,287,157	39,336,177		39,336,177	2,041,609	194,581,725	91,302,670	6
7	HIT DESIGNATED ASSETS								7
8	SUBTOTAL (sum of lines 1-7)	572,657,409	231,487,096		231,487,096	75,224,789	728,919,716	138,166,201	8
9	RECONCILING ITEMS	100,948,771					100,948,771		9
10	TOTAL (line 7 minus line 9)	471,708,638	231,487,096		231,487,096	75,224,789	627,970,945	138,166,201	10

PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 AND 2

	DESCRIPTION	SUMMARY OF CAPITAL							TOTAL(1) (Sum of cols. 9 through 14)	
		DEPREC- IATION	LEASE	INTEREST	INSURANCE (see instr.)	TAXES (see instr.)	OTHER CAPITAL- RELATED COSTS (see instr.)			
*		9	10	11	12	13	14	15		
1	CAP REL COSTS-BLDG & FIXT	8,169,739						8,169,739	1	
2	CAP REL COSTS-MVBLE EQUIP	12,553,263						12,553,263	2	
3	TOTAL (sum of lines 1-2)	20,723,002						20,723,002	3	

(1) The amount in columns 9 through 14 must equal the amount on Worksheet A, column 2, lines 1 and 2. Enter in each column the appropriate amounts including any directly assigned cost that may have been included in Worksheet A, column 2, lines 1 and 2.

* All lines numbers are to be consistent with Worksheet A line numbers for capital cost centers.

PART III - RECONCILIATION OF CAPITAL COST CENTERS

	DESCRIPTION	COMPUTATION OF RATIOS				ALLOCATION OF OTHER CAPITAL				
		GROSS ASSETS	CAPITAL- IZED LEASES	GROSS ASSETS FOR RATIO (col. 1 - col. 2)	RATIO (see instr.)	INSURANCE	TAXES	OTHER CAPITAL- RELATED COSTS	TOTAL (sum of cols. 5 through 7)	
*		9	10	11	12	13	14	15	16	
1	CAP REL COSTS-BLDG & FI	408,404,800	2,333,700	406,071,100	0.649052					1
2	CAP REL COSTS-MVBLE EQU	219,566,145		219,566,145	0.350948					2
3	TOTAL (sum of lines 1-2)	627,970,945	2,333,700	625,637,245	1.000000					3

	DESCRIPTION	SUMMARY OF CAPITAL							TOTAL(2) (sum of cols. 9 through 14)	
		DEPREC- IATION	LEASE	INTEREST	INSURANCE (see instr.)	TAXES (see instr.)	OTHER CAPITAL- RELATED COSTS (see instr.)			
*		9	10	11	12	13	14	15		
1	CAP REL COSTS-BLDG & FIXT	7,888,499			359,417			8,247,916	1	
2	CAP REL COSTS-MVBLE EQUIP	12,455,719						12,455,719	2	
3	TOTAL (sum of lines 1-2)	20,344,218			359,417			20,703,635	3	

(2) The amounts on lines 1 and 2 must equal the corresponding amounts on Worksheet A, column 7, lines 1 and 2. Columns 9 through 14 should include related Worksheet A-6 reclassifications, Worksheet A-8 adjustments, and Worksheet A-8-1 related organizations and home office costs. (See instructions.)



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ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		
				COST CENTER	LINE#	WKST A-7 REF.
		1	2	3	4	5
1	INVESTMENT INCOME-BUILDINGS & FIXTURES (chapter 2)			CAP REL COSTS-BLDG & FIXT	1	1
2	INVESTMENT INCOME-MOVABLE EQUIPMENT (chapter 2)			CAP REL COSTS-MVBLE EQUIP	2	2
3	INVESTMENT INCOME-OTHER (chapter 2)					3
4	TRADE, QUANTITY, AND TIME DISCOUNTS (chapter 8)					4
5	REFUNDS AND REBATES OF EXPENSES (chapter 8)					5
6	RENTAL OF PROVIDER SPACE BY SUPPLIERS (chapter 8)					6
7	TELEPHONE SERVICES (PAY STATIONS EXCL) (chapter 21)	A	-91,908	COMMUNICATIONS	5.01	7
8	TELEVISION AND RADIO SERVICE (chapter 21)					8
9	PARKING LOT (chapter 21)					9
10	PROVIDER-BASED PHYSICIAN ADJUSTMENT	WKST A-8-3	-3,639,621			10
11	SALE OF SCRAP, WASTE, ETC. (chapter 23)					11
12	RELATED ORGANIZATION TRANSACTIONS (chapter 10)	WKST A-8-3				12
13	LAUNDRY AND LINEN SERVICE					13
14	CAFETERIA - EMPLOYEES AND GUESTS	B	-1,027,196	CAFETERIA	11	14
15	RENTAL OF QUARTERS TO EMPLOYEES & OTHERS					15
16	SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS					16
17	SALE OF DRUGS TO OTHER THAN PATIENTS					17
18	SALE OF MEDICAL RECORDS AND ABSTRACTS	A	-77,302	MEDICAL RECORDS & LIBRARY	16	18
19	NURSING SCHOOL (TUITION,FEES,BOOKS,ETC.)					19
20	VENDING MACHINES	B	-15,363	DIETARY	10	20
21	INCOME FROM IMPOSITION OF INTEREST, FINANCE OR PENALTY CHARGES (chapter 21)					21
22	INTEREST EXP ON MEDICARE OVERPAYMENTS & BORROWINGS TO REPAY MEDICARE OVERPAYMENTS					22
23	ADJ FOR RESPIRATORY THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		RESPIRATORY THERAPY	65	23
24	ADJ FOR PHYSICAL THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		PHYSICAL THERAPY	66	24
25	UTIL REVIEW-PHYSICIANS' COMPENSATION (chapter 21)			UTILIZATION REVIEW-SNF	114	25
26	DEPRECIATION--BUILDINGS & FIXTURES			CAP REL COSTS-BLDG & FIXT	1	26
27	DEPRECIATION--MOVABLE EQUIPMENT	A	-42,190	CAP REL COSTS-MVBLE EQUIP	2	9 27
28	NON-PHYSICIAN ANESTHETIST			NONPHYSICIAN ANESTHETISTS	19	28
29	PHYSICIANS' ASSISTANT					29
30	ADJ FOR OCCUPATIONAL THERAPY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		OCCUPATIONAL THERAPY	67	30
31	ADJ FOR SPEECH PATHOLOGY COSTS IN EXCESS OF LIMITATION (chapter 14)	WKST A-8-3		SPEECH PATHOLOGY	68	31
32	CAH HIT ADJ FOR DEPRECIATION AND					32
33	TV DEPRECIATION	A	-42,750	CAP REL COSTS-MVBLE EQUIP	2	9 33
34	INTEREST EXPENSE	A	-12,094,949	CAP REL COSTS-BLDG & FIXT	1	11 34
35	LIFELINE	B	-12,604	CAP REL COSTS-MVBLE EQUIP	2	9 35
36	LIFELINE	B	-42,654	ADMINISTRATIVE & GENERAL	5.06	36
37	MISCELLANEOUS INCOME	B	-746,941	ADMINISTRATIVE & GENERAL	5.06	37
38	MISCELLANEOUS INCOME	B	-41,162	NURSING ADMINISTRATION	13	38
39	DISCOUNTS	B	-39,850	ADMINISTRATIVE & GENERAL	5.06	39
40	SELF INSURANCE FUND INCOME	B	-814,178	ADMINISTRATIVE & GENERAL	5.06	40
41	VISITOR MEAL COST	A	-42,759	DIETARY	10	41
42						42
43	1987 ASSET LIFE ADJUSTMENT	A	-33,771	CAP REL COSTS-BLDG & FIXT	1	9 43
44	PHYSICIANS OFFSET	A	-3,320,248	ADMINISTRATIVE & GENERAL	5.06	44
44.01	PHYSICIANS OFFSET - FICA	A	-244,304	EMPLOYEE BENEFITS DEPARTMENT	4	44.01
45	AHA/IHA LOBBYING EXPENSE	A	-48,761	ADMINISTRATIVE & GENERAL	5.06	45
45.01	NAHC/IHHC LOBBYING EXPENSE	A	-1,353	HOME HEALTH AGENCY	101	45.01
45.02	NHPCO LOBBYING EXPENSE	A	-189	HOSPICE	116	45.02
46	CABLE TV	A	-2,172	ADMINISTRATIVE & GENERAL	5.06	46
46.01	CABLE TV	A	-1,013	CARDIAC REHABILITATION	76.97	46.01
47	CONVENT DEPRECIATION	A	-1,925	CAP REL COSTS-BLDG & FIXT	1	9 47
47.01	REAL ESTATE TAXES	A	-119,449	ADMINISTRATIVE & GENERAL	5.06	47.01
47.02	REAL ESTATE TAXES	A	-100,142	PHYSICIANS' PRIVATE OFFICES	192	47.02
47.03	REAL ESTATE TAXES	A	-579,097	PCC	91.01	47.03
47.04	FUNDRAISING DONATIONS	A	-10,000	ADMINISTRATIVE & GENERAL	5.06	47.04
47.05	ADVERTISING EXPENSE	A	-1,809,000	ADMINISTRATIVE & GENERAL	5.06	47.05
47.06	1990 ASSET LIFE CORRECTION	A	2,026	CAP REL COSTS-BLDG & FIXT	1	9 47.06
47.07	NON-ALLOWABLE EXPENSE - LIQUOR	A	-2,130	ADMINISTRATIVE & GENERAL	5.06	47.07
47.09	PHYSICIAN BILLING	A	-19,164	ADMINISTRATIVE & GENERAL	5.06	47.09
47.11	HOME DELIVERED MEALS REVENUE	B	-51,899	DIETARY	10	47.11
47.12	BABY PHOTO REVENUE	B	-1,420	ADMINISTRATIVE & GENERAL	5.06	47.12
47.15	FALL GALA	A	-134,187	ADMINISTRATIVE & GENERAL	5.06	47.15
47.20	MISC NON-ALLOW (TICKETS)	A	-7,253	ADMINISTRATIVE & GENERAL	5.06	47.20



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ADJUSTMENTS TO EXPENSES

WORKSHEET A-8

	DESCRIPTION(1)	BASIS/ CODE (2)	AMOUNT	EXPENSE CLASSIFICATION ON WORKSHEET A TO/FROM WHICH THE AMOUNT IS TO BE ADJUSTED		WKST A-7 REF.
				COST CENTER	LINE#	
		1	2	3	4	5
48	REIMB OF INTERCOMPANY EXPENSES	B	-58,200	EMPLOYEE BENEFITS DEPARTMENT	4	48
48.01	REIMB OF INTERCOMPANY EXPENSES	B	-212,400	DATA PROCESSING	5.02	48.01
48.02	REIMB OF INTERCOMPANY EXPENSES	B	-15,600	PURCHASING & STORES	5.03	48.02
48.03	REIMB OF INTERCOMPANY EXPENSES	B	-337,200	CASHIERING	5.05	48.03
48.04	REIMB OF INTERCOMPANY EXPENSES	B	-476,160	ADMINISTRATIVE & GENERAL	5.06	48.04
48.05	REIMB OF INTERCOMPANY EXPENSES	B	-11,297	MAINTENANCE & REPAIRS	6	48.05
48.50	ADJUST TO NET PROVIDER TAX	A	-12,217,051	ADMINISTRATIVE & GENERAL	5.06	48.50
49						49
50	TOTAL (sum of lines 1 thru 49) (Transfer to worksheet A, column 6, line 200)		-38,584,786			50

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1

(2) Basis for adjustment (see instructions)

A. Costs - if cost, including applicable overhead, can be determined

B. Amount Received - if cost cannot be determined

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

Note: See instructions for column 5 referencing to Worksheet A-7.



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

WORKSHEET A-8-1

A: COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:

LINE NO.	COST CENTER	EXPENSE ITEMS	AMOUNT OF ALLOWABLE COST	AMOUNT INCLUDED IN WKST. A COLUMN 5	NET ADJUSTMENTS (col. 4 minus col. 5)*	WKST. A-7 REF.
1	2	3	4	5	6	7
1						
2						
3						
4						
5	TOTALS (SUM OF LINES 1-4) TRANSFER COLUMN 6, LINE 5 TO WORKSHEET A-8, COLUMN 2, LINE 12					

* The amounts on lines 1 through 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 have not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

B. INTERRELATIONSHIP OF 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 requested information, the cost report is considered incomplete and not acceptable for purposes of claiming reimbursement under title XVIII.

	SYMBOL (1)	NAME	PERCENTAGE OF OWNERSHIP	RELATED ORGANIZATION(S) AND/OR HOME OFFICE		
				NAME	PERCENTAGE OF OWNERSHIP	TYPE OF BUSINESS
	1	2	3	4	5	6
6						
7						
8						
9						
10						

(1) Use the following symbols to indicate the 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.
- G. Other (financial Or non-financial) specify:



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PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

WKST A LINE #	COST CENTER/ PHYSICIAN IDENTIFIER	TOTAL REMUNERATION	PROFESS- IONAL COMPO- NENT	PROVIDER COMPO- NENT	RCE AMOUNT	PHYSICIAN/ PROVIDER COMPO- NENT HOURS	UNADI- USTED RCE LIMIT	5 PERCENT OF UNADJ- USTED RCE LIMIT	
1	2	3	4	5	6	7	8	9	
1	40 SUBPROVIDER - IPF PSYCHIATRY	50,000	50,000						1
2	31 INTENSIVE CARE UNIT INTENSIVE CARE	31,800		31,800	177,200	350	29,817	1,491	2
3	30 ADULTS & PEDIATRICS NEONATAL	225,000	225,000						3
4	50 OPERATING ROOM OPERATING ROOM	365,410	365,410						4
5	53 ANESTHESIOLOGY ANESTHESIOLOGY	325,000	200,000	125,000	177,200	507	43,193	2,160	5
6	60 LABORATORY LABORATORY	65,100		65,100	215,700	2,859	296,484	14,824	6
7	65 RESPIRATORY THERAPY RESPIRATORY THE	56,400		56,400	177,200	399	33,992	1,700	7
9	70 ELECTROENCEPHALOGRAP SLEEP LAB	12,000	12,000						9
10	66 PHYSICAL THERAPY PHYSICAL THERAP	161,856		161,856	177,200	1,116	95,075	4,754	10
11	5.06 ADMINISTRATIVE & GEN INFECTION CONTR	30,000		30,000	177,200	44	3,748	187	11
12	76.97 CARDIAC REHABILITATI CARDIAC REHAB	200	200						12
13	50 OPERATING ROOM CVOR	750,004	750,004						13
14	30 ADULTS & PEDIATRICS CVU	33,000		33,000	177,200	120	10,223	511	14
15	59 CARDIAC CATHETERIZAT CATH LAB	25,000		25,000	177,200	120	10,223	511	15
16	30 ADULTS & PEDIATRICS CV ADMIN	108,500		108,500	177,200	302	25,728	1,286	16
17	91.01 PCC PCC	1,717,400	1,717,400						17
18	4 EMPLOYEE BENEFITS DE EMPLOYEE HEALTH	50	50						18
19	54 RADIOLOGY-DIAGNOSTIC ALPHA MED								19
200	TOTAL	3,956,720	3,320,064	636,656		5,817	548,483	27,424	200



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PROVIDER-BASED PHYSICIANS ADJUSTMENTS

WORKSHEET A-8-2

	WKST A LINE #	COST CENTER/ PHYSICIAN IDENTIFIER	COST OF MEMBER- SHIPS & CONTIN- UING EDUCATION	PROVIDER COMPON- ENT SHARE OF COL. 12	PHYSICIAN COST OF MALPRACT- ICE INSURANCE	PROVIDER COMPON- ENT SHARE OF COL. 14	ADJUSTED RCE LIMIT	RCE DISALLOW- ANCE	ADJUST- MENT	
	10	11	12	13	14	15	16	17	18	
1	40	SUBPROVIDER - IPF PSYCHIATRY							50,000	1
2	31	INTENSIVE CARE UNIT INTENSIVE CARE					29,817	1,983	1,983	2
3	30	ADULTS & PEDIATRICS NEONATAL							225,000	3
4	50	OPERATING ROOM OPERATING ROOM							365,410	4
5	53	ANESTHESIOLOGY ANESTHESIOLOGY					43,193	81,807	281,807	5
6	60	LABORATORY LABORATORY					296,484			6
7	65	RESPIRATORY THERAPY RESPIRATORY THE					33,992	22,408	22,408	7
9	70	ELECTROENCEPHALOGRAP SLEEP LAB							12,000	9
10	66	PHYSICAL THERAPY PHYSICAL THERAP					95,075	66,781	66,781	10
11	5.06	ADMINISTRATIVE & GEN INFECTION CONTR					3,748	26,252	26,252	11
12	76.97	CARDIAC REHABILITATI CARDIAC REHAB							200	12
13	50	OPERATING ROOM CVOR							750,004	13
14	30	ADULTS & PEDIATRICS CVU					10,223	22,777	22,777	14
15	59	CARDIAC CATHETERIZAT CATH LAB					10,223	14,777	14,777	15
16	30	ADULTS & PEDIATRICS CV ADMIN					25,728	82,772	82,772	16
17	91.01	PCC PCC							1,717,400	17
18	4	EMPLOYEE BENEFITS DE EMPLOYEE HEALTH							50	18
19	54	RADIOLOGY-DIAGNOSTIC ALPHA MED								19
200		TOTAL					548,483	319,557	3,639,621	200



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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS V-VI

CHECK APPLICABLE BOX: OCCUPATIONAL [] PHYSICAL [] RESPIRATORY [] SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION

		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
47	OVERTIME HOURS WORKED DURING REPORTING PERIOD (if column 5, line 47 is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)						47
48	OVERTIME RATE (see instructions)						48
49	TOTAL OVERTIME (INCLUDING BASE AND OVERTIME ALLOWANCE) (multiply line 47 times line 48)						49
CALCULATION OF LIMIT							
50	PERCENTAGE OF OVERTIME HOURS BY CATEGORY (divide the hours in each column on line 47 by the total overtime worked in column 5, line 47)						50
51	ALLOCATION OF PROVIDER'S STANDARD WORK YEAR FOR ONE FULL-TIME EMPLOYEE TIMES THE PERCENTAGES ON LINE 50) (see instructions)						51
DETERMINATION OF OVERTIME ALLOWANCE							
52	ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT (see instructions)						52
53	OVERTIME COST LIMITATION) (line 51 times line 52)						53
54	MAXIMUM OVERTIME COST (enter the lesser of line 49 or line 53)						54
55	PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION AT THE AHSEA (multiply line 47 times line 52)						55
56	OVERTIME ALLOWANCE (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	SALARY EQUIVALENCY AMOUNT (from line 23)						57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (from lines 33, 34, or 35)						58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (from lines 44, 45, or 46)						59
60	OVERTIME ALLOWANCE (from column 5, line 56)						60
61	EQUIPMENT COST (see instructions)						61
62	SUPPLIES (see instructions)						62
63	TOTAL ALLOWANCE (sum of lines 57-62)						63
64	TOTAL COST OF OUTSIDE SUPPLIER SERVICES (from provider records)						64
65	EXCESS OVER LIMITATION (line 64 minus line 63; if negative enter zero)						65



PALOS COMMUNITY HOSPITAL Provider CCN: 14-0062	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 08:45 Version: 2014.03
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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS V-VI

CHECK APPLICABLE BOX: [] OCCUPATIONAL [XX] PHYSICAL [] RESPIRATORY [] SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION

		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
47	OVERTIME HOURS WORKED DURING REPORTING PERIOD (if column 5, line 47 is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)						47
48	OVERTIME RATE (see instructions)						48
49	TOTAL OVERTIME (INCLUDING BASE AND OVERTIME ALLOWANCE) (multiply line 47 times line 48)						49
CALCULATION OF LIMIT							
50	PERCENTAGE OF OVERTIME HOURS BY CATEGORY (divide the hours in each column on line 47 by the total overtime worked in column 5, line 47)						50
51	ALLOCATION OF PROVIDER'S STANDARD WORK YEAR FOR ONE FULL-TIME EMPLOYEE TIMES THE PERCENTAGES ON LINE 50) (see instructions)						51
DETERMINATION OF OVERTIME ALLOWANCE							
52	ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT (see instructions)						52
53	OVERTIME COST LIMITATION) (line 51 times line 52)						53
54	MAXIMUM OVERTIME COST (enter the lesser of line 49 or line 53)						54
55	PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION AT THE AHSEA (multiply line 47 times line 52)						55
56	OVERTIME ALLOWANCE (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

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58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (from lines 33, 34, or 35)						58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (from lines 44, 45, or 46)						59
60	OVERTIME ALLOWANCE (from column 5, line 56)						60
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63	TOTAL ALLOWANCE (sum of lines 57-62)						63
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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS V-VI

CHECK APPLICABLE BOX: OCCUPATIONAL PHYSICAL RESPIRATORY SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION

		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
47	OVERTIME HOURS WORKED DURING REPORTING PERIOD (if column 5, line 47 is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)						47
48	OVERTIME RATE (see instructions)						48
49	TOTAL OVERTIME (INCLUDING BASE AND OVERTIME ALLOWANCE) (multiply line 47 times line 48)						49
CALCULATION OF LIMIT							
50	PERCENTAGE OF OVERTIME HOURS BY CATEGORY (divide the hours in each column on line 47 by the total overtime worked in column 5, line 47)						50
51	ALLOCATION OF PROVIDER'S STANDARD WORK YEAR FOR ONE FULL-TIME EMPLOYEE TIMES THE PERCENTAGES ON LINE 50) (see instructions)						51
DETERMINATION OF OVERTIME ALLOWANCE							
52	ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT (see instructions)						52
53	OVERTIME COST LIMITATION) (line 51 times line 52)						53
54	MAXIMUM OVERTIME COST (enter the lesser of line 49 or line 53)						54
55	PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION AT THE AHSEA (multiply line 47 times line 52)						55
56	OVERTIME ALLOWANCE (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	SALARY EQUIVALENCY AMOUNT (from line 23)						57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (from lines 33, 34, or 35)						58
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60	OVERTIME ALLOWANCE (from column 5, line 56)						60
61	EQUIPMENT COST (see instructions)						61
62	SUPPLIES (see instructions)						62
63	TOTAL ALLOWANCE (sum of lines 57-62)						63
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PALOS COMMUNITY HOSPITAL Provider CCN: 14-0062	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 08:45 Version: 2014.03
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REASONABLE COST DETERMINATION FOR THERAPY SERVICES FURNISHED BY OUTSIDE SUPPLIERS

WORKSHEET A-8-3
PARTS V-VI

CHECK APPLICABLE BOX: OCCUPATIONAL PHYSICAL RESPIRATORY SPEECH PATHOLOGY

PART V - OVERTIME COMPUTATION

		SUPERVISORS	THERAPISTS	ASSISTANTS	AIDES	TRAINEES	
		1	2	3	4	5	
47	OVERTIME HOURS WORKED DURING REPORTING PERIOD (if column 5, line 47 is zero or equal to or greater than 2,080, do not complete lines 48-55 and enter zero in each column of line 56)						47
48	OVERTIME RATE (see instructions)						48
49	TOTAL OVERTIME (INCLUDING BASE AND OVERTIME ALLOWANCE) (multiply line 47 times line 48)						49
CALCULATION OF LIMIT							
50	PERCENTAGE OF OVERTIME HOURS BY CATEGORY (divide the hours in each column on line 47 by the total overtime worked in column 5, line 47)						50
51	ALLOCATION OF PROVIDER'S STANDARD WORK YEAR FOR ONE FULL-TIME EMPLOYEE TIMES THE PERCENTAGES ON LINE 50) (see instructions)						51
DETERMINATION OF OVERTIME ALLOWANCE							
52	ADJUSTED HOURLY SALARY EQUIVALENCY AMOUNT (see instructions)						52
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54	MAXIMUM OVERTIME COST (enter the lesser of line 49 or line 53)						54
55	PORTION OF OVERTIME ALREADY INCLUDED IN HOURLY COMPUTATION AT THE AHSEA (multiply line 47 times line 52)						55
56	OVERTIME ALLOWANCE (line 54 minus line 55 - if negative enter zero) (Enter in column 5 the sum of columns 1, 3, and 4 for respiratory therapy and columns 1 through 3 for all others.)						56

PART VI - COMPUTATION OF THERAPY LIMITATION AND EXCESS COST ADJUSTMENT

57	SALARY EQUIVALENCY AMOUNT (from line 23)						57
58	TRAVEL ALLOWANCE AND EXPENSE - PROVIDER SITE (from lines 33, 34, or 35)						58
59	TRAVEL ALLOWANCE AND EXPENSE - OFFSITE SERVICES (from lines 44, 45, or 46)						59
60	OVERTIME ALLOWANCE (from column 5, line 56)						60
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63	TOTAL ALLOWANCE (sum of lines 57-62)						63
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65	EXCESS OVER LIMITATION (line 64 minus line 63; if negative enter zero)						65



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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	COMMUNI- CATIONS	DATA PROCESSING	
		0	1	2	4	5.01	5.02	
GENERAL SERVICE COST CENTERS								
1	CAP REL COSTS-BLDG & FIXT	8,247,916	8,247,916					1
2	CAP REL COSTS-MVBLE EQUIP	12,455,719		12,455,719				2
4	EMPLOYEE BENEFITS DEPARTMENT	50,863,111	36,680	5,516	50,905,307			4
5.01	COMMUNICATIONS	710,124	14,565	257,086	245,596	1,227,371		5.01
5.02	DATA PROCESSING	6,910,291	81,774	3,526,313	960,056	48,723	11,527,157	5.02
5.03	PURCHASING & STORES	587,568	27,139	23,759	200,942	5,758	87,701	5.03
5.04	ADMITTING	2,516,423	14,978	2,879	1,183,325	13,731	290,508	5.04
5.05	CASHIERING	3,473,413	96,114	17,521	982,383	91,687	553,610	5.05
5.06	ADMINISTRATIVE & GENERAL	20,842,518	991,742	1,140,596	3,706,264	122,693	2,707,758	5.06
6	MAINTENANCE & REPAIRS	6,258,740	1,022,328	813,010	714,460	25,247		6
6.01	CLINICAL ENGINEERING	691,123	11,832	258,122	178,615	4,872	49,332	6.01
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE	1,425,971	44,193	859	66,981			8
9	HOUSEKEEPING	3,718,665	15,701	60,703	1,495,902	7,087		9
10	DIETARY	3,137,308	167,802	60,084	1,607,536	12,402	153,476	10
11	CAFETERIA	980,330	91,700					11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	2,338,996	32,389	8,727	580,499	16,389	504,279	13
14	CENTRAL SERVICES & SUPPLY	3,362,456	350,545	864,413	1,027,037	24,804	109,626	14
15	PHARMACY	4,769,503	89,212	495,789	1,160,998	27,019	285,027	15
16	MEDICAL RECORDS & LIBRARY	3,489,531	64,289	7,584	1,183,325	22,147	942,782	16
17	SOCIAL SERVICE	959,870	12,687	327	290,250	7,087	54,813	17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-PHARMACY RESIDENCY	87,699	338		22,327	443		23
INPATIENT ROUTINE SERV COST CENTERS								
30	ADULTS & PEDIATRICS	38,648,728	2,416,698	190,690	11,699,290	201,535	2,548,801	30
31	INTENSIVE CARE UNIT	6,126,445	243,829	229,159	1,719,170	20,818		31
40	SUBPROVIDER - IPF	4,453,725	171,155	8,470	1,339,613	19,489	43,850	40
43	NURSERY							43
ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	18,528,785	768,910	1,744,662	2,701,554	96,560	471,391	50
51	RECOVERY ROOM	1,477,154	41,037	18,587	424,211	6,644	10,963	51
53	ANESTHESIOLOGY	467,059	9,785	80,067		6,201		53
54	RADIOLOGY-DIAGNOSTIC	9,022,034	195,693	782,121	2,098,728	47,837	515,241	54
54.01	ULTRASOUND	1,463,422	15,786	108,275	334,903			54.01
57	CT SCAN	2,059,489	19,091	298,559	379,557			57
58	MRI	653,701	16,246	348,152	111,634			58
59	CARDIAC CATHETERIZATION	3,039,647	114,689	130,636	513,518	14,617		59
60	LABORATORY	10,660,490	252,178	420,782	2,165,708	58,024	427,541	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.	2,544,350	10,057	6,828	178,615			63
64	INTRAVENOUS THERAPY	1,529,726	7,400	4,394	357,230	7,087		64
65	RESPIRATORY THERAPY	3,108,095	15,110	78,569	848,422	12,845	82,219	65
66	PHYSICAL THERAPY	4,972,320	128,812	17,979	1,428,921	26,576	202,808	66
68	SPEECH PATHOLOGY	247,549		1,189	66,981			68
69	ELECTROCARDIOLOGY	1,980,573	121,506	137,691	647,480	20,375	367,247	69
70	ELECTROENCEPHALOGRAPHY	307,520	9,231	6,127	44,654	1,772		70
70.01	EMG	166,585	2,075	9,097	66,981	4,429		70.01
70.03	ANGIOGRAPHY	1,032,504	11,494	120,379	156,288	1,329		70.03
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	3,540,720						71
72	IMPL. DEV. CHARGED TO PATIENTS	12,543,993						72
73	DRUGS CHARGED TO PATIENTS	9,605,477						73
74	RENAL DIALYSIS	417,714	7,212				5,481	74
76.97	CARDIAC REHABILITATION	966,351		16,569	267,923			76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	OUTPATIENT PSYCHE SERVICES	1,202,148		2,398	379,557			90.01
91	EMERGENCY	7,176,819	314,889	29,679	2,121,054	56,696	723,531	91
91.01	PCC	3,182,953		51,165	1,183,325	104,090	285,027	91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
OTHER REIMBURSABLE COST CENTERS								
101	HOME HEALTH AGENCY	9,756,598	6,761	68,961	2,545,265	38,092	104,145	101
SPECIAL PURPOSE COST CENTERS								
113	INTEREST EXPENSE							113
116	HOSPICE	3,720,466	5,822	277	870,749			116
118	SUBTOTALS (sum of lines 1-117)	302,430,415	8,071,474	12,454,750	50,257,827	1,175,105	11,527,157	118
NONREIMBURSABLE COST CENTERS								
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	253,474	22,528		44,654			190
192	PHYSICIANS' PRIVATE OFFICES	606,096	153,914	425		52,266		192
194	NEW DIRECTION							194



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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	ALLOCATION (from Wkst A, col.7)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	COMMUNI- CATIONS	DATA PROCESSING	
		0	1	2	4	5.01	5.02	
194.01	PRIVATE DUTY NURSING	938,572			558,172			194.01
194.02	PHYSICIAN REFERRAL CENTER	69,915		544	44,654			194.02
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	304,298,472	8,247,916	12,455,719	50,905,307	1,227,371	11,527,157	202



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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	PURCH & STORES A, col.7)	ADMITTING BLDGS & FIXTURES 5.04	CASHIERING MOVABLE EQUIPMENT 5.05	SUBTOTAL (cols.0-4) 4A	ADMINIS-TRATIVE & GENERAL 5.06	MAIN-TENANCE & REPAIRS 6	
GENERAL SERVICE COST CENTERS								
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.01	COMMUNICATIONS							5.01
5.02	DATA PROCESSING							5.02
5.03	PURCHASING & STORES	932,867						5.03
5.04	ADMITTING	1,305	4,023,149					5.04
5.05	CASHIERING	1,972		5,216,700				5.05
5.06	ADMINISTRATIVE & GENERAL	52,816			29,564,387	29,564,387		5.06
6	MAINTENANCE & REPAIRS	82,696			8,916,481	959,511	9,875,992	6
6.01	CLINICAL ENGINEERING	9,552			1,203,448	129,504	19,598	6.01
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE	15,301			1,553,305	167,153	73,197	8
9	HOUSEKEEPING	8,497			5,306,555	571,044	26,006	9
10	DIETARY	12,302			5,150,910	554,295	277,935	10
11	CAFETERIA				1,072,030	115,362	151,885	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	7,248			3,488,527	375,404	53,646	13
14	CENTRAL SERVICES & SUPPLY	118,490			5,857,371	630,318	580,617	14
15	PHARMACY	11,274			6,838,822	735,932	147,763	15
16	MEDICAL RECORDS & LIBRARY	3,527			5,713,185	614,802	106,483	16
17	SOCIAL SERVICE	1,666			1,326,700	142,768	21,014	17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-PHARMACY RESIDENCY				110,807	11,924	560	23
INPATIENT ROUTINE SERV COST CENTERS								
30	ADULTS & PEDIATRICS	41,514	721,972	936,448	57,405,676	6,177,459	4,002,833	30
31	INTENSIVE CARE UNIT	5,248	100,394	130,169	8,575,232	922,789	403,861	31
40	SUBPROVIDER - IPF	8,969	84,451	109,498	6,239,220	671,409	283,488	40
43	NURSERY							43
ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	73,587	555,861	720,720	25,662,030	2,761,517	1,273,565	50
51	RECOVERY ROOM	2,666	43,628	56,567	2,081,457	223,988	67,971	51
53	ANESTHESIOLOGY	6,720	120,931	156,797	847,560	91,207	16,207	53
54	RADIOLOGY-DIAGNOSTIC	48,540	114,215	148,089	12,972,498	1,395,983	324,131	54
54.01	ULTRASOUND	2,222	50,694	65,729	2,041,031	219,637	26,146	54.01
57	CT SCAN	1,944	223,393	289,648	3,271,681	352,069	31,621	57
58	MRI	666	36,848	47,776	1,215,023	130,750	26,908	58
59	CARDIAC CATHETERIZATION	134,651	113,775	147,519	4,209,052	452,940	189,962	59
60	LABORATORY	153,647	608,221	788,609	15,535,200	1,671,758	417,688	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.	5,665	34,753	45,060	2,825,328	304,036	16,658	63
64	INTRAVENOUS THERAPY	555	5,177	6,713	1,918,282	206,428	12,257	64
65	RESPIRATORY THERAPY	7,553	222,096	287,966	4,662,875	501,777	25,026	65
66	PHYSICAL THERAPY	30,407	50,382	65,325	6,923,530	745,048	213,355	66
68	SPEECH PATHOLOGY	333	7,046	9,136	332,234	35,752		68
69	ELECTROCARDIOLOGY	4,415	119,203	154,556	3,553,046	382,347	201,254	69
70	ELECTROENCEPHALOGRAPHY	250	4,062	5,267	378,883	40,772	15,290	70
70.01	EMG	1,555	1,063	1,379	253,164	27,243	3,437	70.01
70.03	ANGIOGRAPHY	19,910	30,090	39,014	1,411,008	151,840	19,038	70.03
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		143,229	185,708	3,869,657	416,418		71
72	IMPL. DEV. CHARGED TO PATIENTS		126,346	163,818	12,834,157	1,381,096		72
73	DRUGS CHARGED TO PATIENTS		284,659	369,084	10,259,220	1,104,005		73
74	RENAL DIALYSIS	1,916	9,902	12,839	455,064	48,970	11,946	74
76.97	CARDIAC REHABILITATION	4,443	4,126	5,350	1,264,762	136,102		76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	OUTPATIENT PSYCHE SERVICES	2,416	44	57	1,586,620	170,738		90.01
91	EMERGENCY	8,858	206,277	267,455	10,905,258	1,173,526	521,558	91
91.01	PCC	20,243	311	404	4,827,518	519,494		91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
OTHER REIMBURSABLE COST CENTERS								
101	HOME HEALTH AGENCY	16,161			12,535,983	1,349,010	11,199	101
SPECIAL PURPOSE COST CENTERS								
113	INTEREST EXPENSE							113
116	HOSPICE	972			4,598,286	494,826	9,644	116
118	SUBTOTALS (sum of lines 1-117)	932,672	4,023,149	5,216,700	301,553,063	29,268,951	9,583,747	118
NONREIMBURSABLE COST CENTERS								
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	56			320,712	34,512	37,314	190
192	PHYSICIANS' PRIVATE OFFICES				812,701	87,456	254,931	192
194	NEW DIRECTION							194



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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	PURCH & STORES A, col.7 5.03	ADMITTING BLDGS & FIXTURES 5.04	CASHIERING MOVABLE EQUIPMENT 5.05	SUBTOTAL (cols.0-4) 4A	ADMINIS-TRATIVE & GENERAL 5.06	MAIN-TENANCE & REPAIRS 6	
194.01	PRIVATE DUTY NURSING	111			1,496,855	161,078		194.01
194.02	PHYSICIAN REFERRAL CENTER	28			115,141	12,390		194.02
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	932,867	4,023,149	5,216,700	304,298,472	29,564,387	9,875,992	202



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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	CLINICAL ENGINEER A, col.7) 6.01	LAUNDRY & LINEN SERVICE 8	HOUSE-KEEPING EQUIPMENT 9	DIETARY SUBTOTAL (cols.0-4) 10	CAFETERIA TRATIVE & GENERAL 11	NURSING ADMINIS-TRATION 13	
GENERAL SERVICE COST CENTERS								
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.01	COMMUNICATIONS							5.01
5.02	DATA PROCESSING							5.02
5.03	PURCHASING & STORES							5.03
5.04	ADMITTING							5.04
5.05	CASHIERING							5.05
5.06	ADMINISTRATIVE & GENERAL							5.06
6	MAINTENANCE & REPAIRS							6
6.01	CLINICAL ENGINEERING	1,352,550						6.01
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE		1,793,655					8
9	HOUSEKEEPING	1,414	64,424	5,969,443				9
10	DIETARY	177	1,137	97,441	6,081,895			10
11	CAFETERIA					1,339,277		11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	50,036		48,189		22,879	4,038,681	13
14	CENTRAL SERVICES & SUPPLY	113,331	10,516	139,607		40,477		14
15	PHARMACY		758	81,497		45,757		15
16	MEDICAL RECORDS & LIBRARY			56,339		46,637		16
17	SOCIAL SERVICE			12,402		11,439		17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-PHARMACY RESIDENCY			2,126		880		23
INPATIENT ROUTINE SERV COST CENTERS								
30	ADULTS & PEDIATRICS	195,899	813,739	2,634,464	5,331,993	461,090	2,222,971	30
31	INTENSIVE CARE UNIT	39,250	104,879	259,726	98,123	67,756	326,658	31
40	SUBPROVIDER - IPF	5,304	38,939	221,812	482,581	52,797	254,539	40
43	NURSERY							43
ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	246,288	240,645	619,728		106,473	513,320	50
51	RECOVERY ROOM	19,979	26,338	72,993		16,719	80,604	51
53	ANESTHESIOLOGY	53,041		28,347				53
54	RADIOLOGY-DIAGNOSTIC	227,723	125,817	392,601		82,715		54
54.01	ULTRASOUND	10,078				13,199		54.01
57	CT SCAN	5,127				14,959		57
58	MRI	4,243				4,400		58
59	CARDIAC CATHETERIZATION	44,555	18,285	98,150		20,239	97,573	59
60	LABORATORY	58,168		155,906		85,355		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.	11,846				7,040		63
64	INTRAVENOUS THERAPY	177		10,984		14,079	67,877	64
65	RESPIRATORY THERAPY	91,231		33,662		33,438		65
66	PHYSICAL THERAPY	47,737	22,738	118,347		56,317		66
68	SPEECH PATHOLOGY					2,640		68
69	ELECTROCARDIOLOGY	44,024	39,034	51,378		25,518		69
70	ELECTROENCEPHALOGRAPHY	2,122	758	10,984		1,760		70
70.01	EMG	1,414				2,640		70.01
70.03	ANGIOGRAPHY	3,890				6,160		70.03
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS	707						74
76.97	CARDIAC REHABILITATION	20,156				10,559		76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	OUTPATIENT PSYCHE SERVICES	354			31,781		72,119	90.01
91	EMERGENCY	42,963	205,591	666,145	137,417	83,595	403,020	91
91.01	PCC	10,255	80,057	156,615				91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
OTHER REIMBURSABLE COST CENTERS								
101	HOME HEALTH AGENCY	1,061				1,760		101
SPECIAL PURPOSE COST CENTERS								
113	INTEREST EXPENSE							113
116	HOSPICE							116
118	SUBTOTALS (sum of lines 1-117)	1,352,550	1,793,655	5,969,443	6,081,895	1,339,277	4,038,681	118
NONREIMBURSABLE COST CENTERS								
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN							190
192	PHYSICIANS' PRIVATE OFFICES							192
194	NEW DIRECTION							194



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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	CLINICAL ENGINEER A, col.7)	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING EQUIPMENT	DIETARY SUBTOTAL (cols.0-4)	CAFETERIA TRATIVE & GENERAL	NURSING ADMINIS- TRATION	
		6.01	8	9	10	11	13	
194.01	PRIVATE DUTY NURSING							194.01
194.02	PHYSICIAN REFERRAL CENTER							194.02
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	1,352,550	1,793,655	5,969,443	6,081,895	1,339,277	4,038,681	202



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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY 14	PHARMACY & LINEN SERVICE 15	MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE (cols.0-4) 17	PARAMED EDUCATION GENERAL 23	SUBTOTAL 24	
GENERAL SERVICE COST CENTERS								
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.01	COMMUNICATIONS							5.01
5.02	DATA PROCESSING							5.02
5.03	PURCHASING & STORES							5.03
5.04	ADMITTING							5.04
5.05	CASHIERING							5.05
5.06	ADMINISTRATIVE & GENERAL							5.06
6	MAINTENANCE & REPAIRS							6
6.01	CLINICAL ENGINEERING							6.01
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION							13
14	CENTRAL SERVICES & SUPPLY	7,372,237						14
15	PHARMACY	134,721	7,985,250					15
16	MEDICAL RECORDS & LIBRARY	371		6,537,817				16
17	SOCIAL SERVICE	243			1,514,566			17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-PHARMACY RESIDENCY					126,297		23
INPATIENT ROUTINE SERV COST CENTERS								
30	ADULTS & PEDIATRICS	681,088	8,089	4,066,734	1,318,743		85,320,778	30
31	INTENSIVE CARE UNIT	110,492	201	75,338	82,613		11,066,918	31
40	SUBPROVIDER - IPF	15,629	32	131,088			8,396,838	40
43	NURSERY							43
ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	2,117,997	924	477,642			34,020,129	50
51	RECOVERY ROOM	14,393	8				2,604,450	51
53	ANESTHESIOLOGY	140,191					1,176,553	53
54	RADIOLOGY-DIAGNOSTIC	92,319	28,560	170,263			15,812,610	54
54.01	ULTRASOUND	13,868	67	45,203			2,369,229	54.01
57	CT SCAN	181,742	2,319	45,203			3,904,721	57
58	MRI	101	204	19,588			1,401,217	58
59	CARDIAC CATHETERIZATION	357,626	10,588				5,498,970	59
60	LABORATORY	410,311	278	531,885			18,866,549	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.	5,875					3,170,783	63
64	INTRAVENOUS THERAPY	99,331					2,329,415	64
65	RESPIRATORY THERAPY	94,891		4,520			5,447,420	65
66	PHYSICAL THERAPY	56,146	344	27,122			8,210,684	66
68	SPEECH PATHOLOGY						370,626	68
69	ELECTROCARDIOLOGY	46,278	128	76,845			4,419,852	69
70	ELECTROENCEPHALOGRAPHY	680		3,014			454,263	70
70.01	EMG	489	796				289,183	70.01
70.03	ANGIOGRAPHY	24,941	26				1,616,903	70.03
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,433,274					6,719,349	71
72	IMPL. DEV. CHARGED TO PATIENTS						14,215,253	72
73	DRUGS CHARGED TO PATIENTS		7,577,947			126,297	19,067,469	73
74	RENAL DIALYSIS		37				516,724	74
76.97	CARDIAC REHABILITATION	281	45	6,027			1,437,932	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	OUTPATIENT PSYCHE SERVICES	199		12,054			1,873,865	90.01
91	EMERGENCY	156,333	6,235	613,250	113,210		15,028,101	91
91.01	PCC	59,501	27,318	232,041			5,912,799	91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
OTHER REIMBURSABLE COST CENTERS								
101	HOME HEALTH AGENCY	121,037	4,343				14,024,393	101
SPECIAL PURPOSE COST CENTERS								
113	INTEREST EXPENSE							113
116	HOSPICE	1,849	316,761				5,421,366	116
118	SUBTOTALS (sum of lines 1-117)	7,372,197	7,985,250	6,537,817	1,514,566	126,297	300,965,342	118
NONREIMBURSABLE COST CENTERS								
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	40					392,578	190
192	PHYSICIANS' PRIVATE OFFICES						1,155,088	192
194	NEW DIRECTION							194



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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY 14	PHARMACY & LINEN SERVICE 15	MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE (cols.0-4) 17	PARAMED EDUCATION GENERAL 23	SUBTOTAL 24	
194.01	PRIVATE DUTY NURSING						1,657,933	194.01
194.02	PHYSICIAN REFERRAL CENTER						127,531	194.02
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	7,372,237	7,985,250	6,537,817	1,514,566	126,297	304,298,472	202



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COST ALLOCATION - GENERAL SERVICE COSTS

WORKSHEET B
PART I

	COST CENTER DESCRIPTIONS	I&R COST & POST STEP-DOWN ADJS	TOTAL				
		25	26				
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS DEPARTMENT						4
5.01	COMMUNICATIONS						5.01
5.02	DATA PROCESSING						5.02
5.03	PURCHASING & STORES						5.03
5.04	ADMITTING						5.04
5.05	CASHIERING						5.05
5.06	ADMINISTRATIVE & GENERAL						5.06
6	MAINTENANCE & REPAIRS						6
6.01	CLINICAL ENGINEERING						6.01
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE						8
9	HOUSEKEEPING						9
10	DIETARY						10
11	CAFETERIA						11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION						13
14	CENTRAL SERVICES & SUPPLY						14
15	PHARMACY						15
16	MEDICAL RECORDS & LIBRARY						16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SERVICES-SALARY & FRINGES APPRVD						21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-PHARMACY RESIDENCY						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS		85,320,778				30
31	INTENSIVE CARE UNIT		11,066,918				31
40	SUBPROVIDER - IPF		8,396,838				40
43	NURSERY						43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM		34,020,129				50
51	RECOVERY ROOM		2,604,450				51
53	ANESTHESIOLOGY		1,176,553				53
54	RADIOLOGY-DIAGNOSTIC		15,812,610				54
54.01	ULTRASOUND		2,369,229				54.01
57	CT SCAN		3,904,721				57
58	MRI		1,401,217				58
59	CARDIAC CATHETERIZATION		5,498,970				59
60	LABORATORY		18,866,549				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	BLOOD STORING, PROCESSING & TRANS.		3,170,783				63
64	INTRAVENOUS THERAPY		2,329,415				64
65	RESPIRATORY THERAPY		5,447,420				65
66	PHYSICAL THERAPY		8,210,684				66
68	SPEECH PATHOLOGY		370,626				68
69	ELECTROCARDIOLOGY		4,419,852				69
70	ELECTROENCEPHALOGRAPHY		454,263				70
70.01	EMG		289,183				70.01
70.03	ANGIOGRAPHY		1,616,903				70.03
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		6,719,349				71
72	IMPL. DEV. CHARGED TO PATIENTS		14,215,253				72
73	DRUGS CHARGED TO PATIENTS		19,067,469				73
74	RENAL DIALYSIS		516,724				74
76.97	CARDIAC REHABILITATION		1,437,932				76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	OUTPATIENT PSYCHE SERVICES		1,873,865				90.01
91	EMERGENCY		15,028,101				91
91.01	PCC		5,912,799				91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
101	HOME HEALTH AGENCY		14,024,393				101
	SPECIAL PURPOSE COST CENTERS						
113	INTEREST EXPENSE						113
116	HOSPICE		5,421,366				116
118	SUBTOTALS (sum of lines 1-117)		300,965,342				118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		392,578				190
192	PHYSICIANS' PRIVATE OFFICES		1,155,088				192
194	NEW DIRECTION						194



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COST ALLOCATION - GENERAL SERVICE COSTS

**WORKSHEET B
PART I**

	COST CENTER DESCRIPTIONS	I&R COST & POST STEP- DOWN ADJS	TOTAL					
		25	26					
194.01	PRIVATE DUTY NURSING		1,657,933					194.01
194.02	PHYSICIAN REFERRAL CENTER		127,531					194.02
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)		304,298,472					202



COMPU-MAX

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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	EMPLOYEE BENEFITS DEPARTMENT	COMMUNI- CATIONS	
		0	1	2	2A	4	5.01	
GENERAL SERVICE COST CENTERS								
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT		36,680	5,516	42,196	42,196		4
5.01	COMMUNICATIONS		14,565	257,086	271,651	204	271,855	5.01
5.02	DATA PROCESSING	22	81,774	3,526,313	3,608,109	796	10,792	5.02
5.03	PURCHASING & STORES	1,074	27,139	23,759	51,972	167	1,275	5.03
5.04	ADMITTING		14,978	2,879	17,857	981	3,041	5.04
5.05	CASHIERING		96,114	17,521	113,635	814	20,308	5.05
5.06	ADMINISTRATIVE & GENERAL	132,525	991,742	1,140,596	2,264,863	3,072	27,176	5.06
6	MAINTENANCE & REPAIRS	545	1,022,328	813,010	1,835,883	592	5,592	6
6.01	CLINICAL ENGINEERING		11,832	258,122	269,954	148	1,079	6.01
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE		44,193	859	45,052	56		8
9	HOUSEKEEPING		15,701	60,703	76,404	1,240	1,570	9
10	DIETARY	5,088	167,802	60,084	232,974	1,333	2,747	10
11	CAFETERIA		91,700		91,700			11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	3,425	32,389	8,727	44,541	481	3,630	13
14	CENTRAL SERVICES & SUPPLY	57,338	350,545	864,413	1,272,296	851	5,494	14
15	PHARMACY		89,212	495,789	585,001	962	5,985	15
16	MEDICAL RECORDS & LIBRARY		64,289	7,584	71,873	981	4,905	16
17	SOCIAL SERVICE		12,687	327	13,014	241	1,570	17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-PHARMACY RESIDENCY		338		338	19	98	23
INPATIENT ROUTINE SERV COST CENTERS								
30	ADULTS & PEDIATRICS	6,978	2,416,698	190,690	2,614,366	9,693	44,638	30
31	INTENSIVE CARE UNIT		243,829	229,159	472,988	1,425	4,611	31
40	SUBPROVIDER - IFF	341	171,155	8,470	179,966	1,110	4,317	40
43	NURSERY							43
ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	28,779	768,910	1,744,662	2,542,351	2,239	21,387	50
51	RECOVERY ROOM		41,037	18,587	59,624	352	1,472	51
53	ANESTHESIOLOGY		9,785	80,067	89,852		1,374	53
54	RADIOLOGY-DIAGNOSTIC	782,091	195,693	782,121	1,759,905	1,740	10,596	54
54.01	ULTRASOUND		15,786	108,275	124,061	278		54.01
57	CT SCAN		19,091	298,559	317,650	315		57
58	MRI		16,246	348,152	364,398	93		58
59	CARDIAC CATHETERIZATION		114,689	130,636	245,325	426	3,238	59
60	LABORATORY		252,178	420,782	672,960	1,795	12,852	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.		10,057	6,828	16,885	148		63
64	INTRAVENOUS THERAPY		7,400	4,394	11,794	296	1,570	64
65	RESPIRATORY THERAPY	15,407	15,110	78,569	109,086	703	2,845	65
66	PHYSICAL THERAPY	39,680	128,812	17,979	186,471	1,184	5,886	66
68	SPEECH PATHOLOGY			1,189	1,189	56		68
69	ELECTROCARDIOLOGY		121,506	137,691	259,197	537	4,513	69
70	ELECTROENCEPHALOGRAPHY	13,200	9,231	6,127	28,558	37	392	70
70.01	EMG		2,075	9,097	11,172	56	981	70.01
70.03	ANGIOGRAPHY		11,494	120,379	131,873	130	294	70.03
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS		7,212		7,212			74
76.97	CARDIAC REHABILITATION			16,569	16,569	222		76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	OUTPATIENT PSYCHE SERVICES			2,398	2,398	315		90.01
91	EMERGENCY		314,889	29,679	344,568	1,758	12,558	91
91.01	PCC	59,400		51,165	110,565	981	23,055	91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
OTHER REIMBURSABLE COST CENTERS								
101	HOME HEALTH AGENCY		6,761	68,961	75,722	2,110	8,437	101
SPECIAL PURPOSE COST CENTERS								
113	INTEREST EXPENSE							113
116	HOSPICE	291,438	5,822	277	297,537	722		116
118	SUBTOTALS (sum of lines 1-117)	1,437,331	8,071,474	12,454,750	21,963,555	41,659	260,278	118
NONREIMBURSABLE COST CENTERS								
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		22,528		22,528	37		190
192	PHYSICIANS' PRIVATE OFFICES		153,914	425	154,339		11,577	192
194	NEW DIRECTION							194



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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	DIR ASSGND CAP-REL COSTS	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	SUBTOTAL	EMPLOYEE BENEFITS DEPARTMENT	COMMUNI- CATIONS	
		0	1	2	2A	4	5.01	
194.01	PRIVATE DUTY NURSING					463		194.01
194.02	PHYSICIAN REFERRAL CENTER			544	544	37		194.02
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	1,437,331	8,247,916	12,455,719	22,140,966	42,196	271,855	202



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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	DATA PROCESSING COSTS	PURCH & STORES FIXTURES	ADMITTING MOVABLE EQUIPMENT	CASHIERING SUBTOTAL	ADMINIS-TRATIVE & GENERAL	MAIN-TENANCE & REPAIRS	
		5.02	5.03	5.04	5.05	5.06	6	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.01	COMMUNICATIONS							5.01
5.02	DATA PROCESSING	3,619,697						5.02
5.03	PURCHASING & STORES	27,539	80,953					5.03
5.04	ADMITTING	91,224	113	113,216				5.04
5.05	CASHIERING	173,842	171		308,770			5.05
5.06	ADMINISTRATIVE & GENERAL	850,276	4,583			3,149,970		5.06
6	MAINTENANCE & REPAIRS		7,176			102,236	1,951,479	6
6.01	CLINICAL ENGINEERING	15,491	829			13,799	3,873	6.01
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE		1,328			17,810	14,464	8
9	HOUSEKEEPING		737			60,845	5,139	9
10	DIETARY	48,194	1,068			59,060	54,920	10
11	CAFETERIA					12,292	30,012	11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	158,351	629			39,999	10,600	13
14	CENTRAL SERVICES & SUPPLY	34,424	10,282			67,161	114,729	14
15	PHARMACY	89,503	978			78,414	29,198	15
16	MEDICAL RECORDS & LIBRARY	296,047	306			65,507	21,041	16
17	SOCIAL SERVICE	17,212	145			15,212	4,152	17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-PHARMACY RESIDENCY					1,271	111	23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	800,361	3,603	20,098	55,488	658,084	790,952	30
31	INTENSIVE CARE UNIT		455	2,832	7,703	98,324	79,802	31
40	SUBPROVIDER - IPF	13,770	778	2,382	6,479	71,539	56,017	40
43	NURSERY							43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	148,024	6,386	15,680	42,648	294,241	251,654	50
51	RECOVERY ROOM	3,442	231	1,231	3,347	23,866	13,431	51
53	ANESTHESIOLOGY		583	3,411	9,278	9,718	3,203	53
54	RADIOLOGY-DIAGNOSTIC	161,793	4,212	3,222	8,763	148,743	64,048	54
54.01	ULTRASOUND		193	1,430	3,889	23,402	5,166	54.01
57	CT SCAN		169	6,301	17,140	37,513	6,248	57
58	MRI		58	1,039	2,827	13,931	5,317	58
59	CARDIAC CATHETERIZATION		11,685	3,209	8,729	48,261	37,536	59
60	LABORATORY	134,254	13,333	17,156	46,666	178,127	82,534	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.		492	980	2,666	32,395	3,292	63
64	INTRAVENOUS THERAPY		48	146	397	21,995	2,422	64
65	RESPIRATORY THERAPY	25,818	655	6,265	17,040	53,465	4,945	65
66	PHYSICAL THERAPY	63,685	2,639	1,421	3,866	79,385	42,159	66
68	SPEECH PATHOLOGY		29	199	541	3,809		68
69	ELECTROCARDIOLOGY	115,321	383	3,362	9,146	40,739	39,767	69
70	ELECTROENCEPHALOGRAPHY		22	115	312	4,344	3,021	70
70.01	EMG		135	30	82	2,903	679	70.01
70.03	ANGIOGRAPHY		1,728	849	2,309	16,179	3,762	70.03
71	MEDICAL SUPPLIES CHARGED TO PATIENTS			4,040	10,989	44,369		71
72	IMPL. DEV. CHARGED TO PATIENTS			3,564	9,694	147,156		72
73	DRUGS CHARGED TO PATIENTS			8,030	21,840	117,632		73
74	RENAL DIALYSIS	1,721	166	279	760	5,218	2,360	74
76.97	CARDIAC REHABILITATION		386	116	317	14,502		76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT PSYCHE SERVICES		210	1	3	18,192		90.01
91	EMERGENCY	227,199	769	5,819	15,827	125,040	103,059	91
91.01	PCC	89,503	1,757	9	24	55,352		91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
101	HOME HEALTH AGENCY	32,703	1,402			143,738	2,213	101
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
116	HOSPICE		84			52,724	1,906	116
118	SUBTOTALS (sum of lines 1-117)	3,619,697	80,936	113,216	308,770	3,118,492	1,893,732	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		5			3,677	7,373	190
192	PHYSICIANS' PRIVATE OFFICES					9,318	50,374	192
194	NEW DIRECTION							194



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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	DATA PROCESSING COSTS	PURCH & STORES FIXTURES	ADMITTING MOVABLE EQUIPMENT	CASHIERING SUBTOTAL	ADMINIS- TRATIVE & GENERAL	MAIN- TENANCE & REPAIRS	
		5.02	5.03	5.04	5.05	5.06	6	
194.01	PRIVATE DUTY NURSING		10			17,163		194.01
194.02	PHYSICIAN REFERRAL CENTER		2			1,320		194.02
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	3,619,697	80,953	113,216	308,770	3,149,970	1,951,479	202



COMPU-MAX

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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	CLINICAL ENGINEER COSTS	LAUNDRY & LINEN SERVICE	HOUSE-KEEPING EQUIPMENT	DIETARY SUBTOTAL	CAFETERIA TRATIVE & GENERAL	NURSING ADMINIS-TRATION	
		6.01	8	9	10	11	13	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.01	COMMUNICATIONS							5.01
5.02	DATA PROCESSING							5.02
5.03	PURCHASING & STORES							5.03
5.04	ADMITTING							5.04
5.05	CASHIERING							5.05
5.06	ADMINISTRATIVE & GENERAL							5.06
6	MAINTENANCE & REPAIRS							6
6.01	CLINICAL ENGINEERING	305,173						6.01
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE		78,710					8
9	HOUSEKEEPING	319	2,827	149,081				9
10	DIETARY	40	50	2,434	402,820			10
11	CAFETERIA					134,004		11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	11,289		1,203		2,289	273,012	13
14	CENTRAL SERVICES & SUPPLY	25,571	461	3,487		4,050		14
15	PHARMACY		33	2,035		4,578		15
16	MEDICAL RECORDS & LIBRARY			1,407		4,666		16
17	SOCIAL SERVICE			310		1,145		17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-PHARMACY RESIDENCY			53		88		23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	44,200	35,710	65,793	353,152	46,137	150,271	30
31	INTENSIVE CARE UNIT	8,856	4,602	6,486	6,499	6,779	22,082	31
40	SUBPROVIDER - IPF	1,197	1,709	5,540	31,963	5,283	17,207	40
43	NURSERY							43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	55,567	10,560	15,477		10,653	34,700	50
51	RECOVERY ROOM	4,508	1,156	1,823		1,673	5,449	51
53	ANESTHESIOLOGY	11,968		708				53
54	RADIOLOGY-DIAGNOSTIC	51,381	5,521	9,805		8,276		54
54.01	ULTRASOUND	2,274				1,321		54.01
57	CT SCAN	1,157				1,497		57
58	MRI	957				440		58
59	CARDIAC CATHETERIZATION	10,053	802	2,451		2,025	6,596	59
60	LABORATORY	13,124		3,894		8,540		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.	2,673				704		63
64	INTRAVENOUS THERAPY	40		274		1,409	4,588	64
65	RESPIRATORY THERAPY	20,584		841		3,346		65
66	PHYSICAL THERAPY	10,771	998	2,956		5,635		66
68	SPEECH PATHOLOGY					264		68
69	ELECTROCARDIOLOGY	9,933	1,713	1,283		2,553		69
70	ELECTROENCEPHALOGRAPHY	479	33	274		176		70
70.01	EMG	319				264		70.01
70.03	ANGIOGRAPHY	878				616		70.03
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS	160						74
76.97	CARDIAC REHABILITATION	4,548				1,057		76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT PSYCHE SERVICES	80			2,105		4,875	90.01
91	EMERGENCY	9,694	9,022	16,636	9,101	8,364	27,244	91
91.01	PCC	2,314	3,513	3,911				91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
101	HOME HEALTH AGENCY	239				176		101
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
116	HOSPICE							116
118	SUBTOTALS (sum of lines 1-117)	305,173	78,710	149,081	402,820	134,004	273,012	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN							190
192	PHYSICIANS' PRIVATE OFFICES							192
194	NEW DIRECTION							194



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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	CLINICAL ENGINEER COSTS	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING EQUIPMENT	DIETARY SUBTOTAL	CAFETERIA TRATIVE & GENERAL	NURSING ADMINIS- TRATION	
		6.01	8	9	10	11	13	
194.01	PRIVATE DUTY NURSING							194.01
194.02	PHYSICIAN REFERRAL CENTER							194.02
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	305,173	78,710	149,081	402,820	134,004	273,012	202



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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY	PHARMACY & LINEN SERVICE	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE SUBTOTAL	PARAMED EDUCATION GENERAL	SUBTOTAL	
		14	15	16	17	23	24	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.01	COMMUNICATIONS							5.01
5.02	DATA PROCESSING							5.02
5.03	PURCHASING & STORES							5.03
5.04	ADMITTING							5.04
5.05	CASHIERING							5.05
5.06	ADMINISTRATIVE & GENERAL							5.06
6	MAINTENANCE & REPAIRS							6
6.01	CLINICAL ENGINEERING							6.01
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION							13
14	CENTRAL SERVICES & SUPPLY	1,538,806						14
15	PHARMACY	28,120	824,807					15
16	MEDICAL RECORDS & LIBRARY	77		466,810				16
17	SOCIAL SERVICE	51			53,052			17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-PHARMACY RESIDENCY					1,978		23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	142,164	836	290,370	46,192		6,172,108	30
31	INTENSIVE CARE UNIT	23,063	21	5,379	2,894		754,801	31
40	SUBPROVIDER - IPF	3,262	3	9,360			411,882	40
43	NURSERY							43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	442,090	95	34,104			3,927,856	50
51	RECOVERY ROOM	3,004	1				124,610	51
53	ANESTHESIOLOGY	29,262					159,357	53
54	RADIOLOGY-DIAGNOSTIC	19,270	2,950	12,157			2,272,382	54
54.01	ULTRASOUND	2,895	7	3,228			168,144	54.01
57	CT SCAN	37,935	239	3,228			429,392	57
58	MRI	21	21	1,399			390,501	58
59	CARDIAC CATHETERIZATION	74,647	1,094				456,077	59
60	LABORATORY	85,644	29	37,977			1,308,885	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.	1,226					61,461	63
64	INTRAVENOUS THERAPY	20,733					65,712	64
65	RESPIRATORY THERAPY	19,807		323			265,723	65
66	PHYSICAL THERAPY	11,719	36	1,937			420,748	66
68	SPEECH PATHOLOGY						6,087	68
69	ELECTROCARDIOLOGY	9,660	13	5,487			503,607	69
70	ELECTROENCEPHALOGRAPHY	142		215			38,120	70
70.01	EMG	102	82				16,805	70.01
70.03	ANGIOGRAPHY	5,206	3				163,827	70.03
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	507,897					567,295	71
72	IMPL. DEV. CHARGED TO PATIENTS						160,414	72
73	DRUGS CHARGED TO PATIENTS		782,734				930,236	73
74	RENAL DIALYSIS		4				17,880	74
76.97	CARDIAC REHABILITATION	59	5	430			38,211	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT PSYCHE SERVICES	41		861			29,081	90.01
91	EMERGENCY	32,631	644	43,787	3,966		997,686	91
91.01	PCC	12,420	2,822	16,568			322,794	91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
101	HOME HEALTH AGENCY	25,264	449				292,453	101
	SPECIAL PURPOSE COST CENTERS							
113	INTEREST EXPENSE							113
116	HOSPICE	386	32,719				386,078	116
118	SUBTOTALS (sum of lines 1-117)	1,538,798	824,807	466,810	53,052		21,860,213	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	8					33,628	190
192	PHYSICIANS' PRIVATE OFFICES						225,608	192
194	NEW DIRECTION							194



COMPU-MAX

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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	CENTRAL SERVICES & SUPPLY 14	PHARMACY & LINEN SERVICE 15	MEDICAL RECORDS & LIBRARY 16	SOCIAL SERVICE SUBTOTAL 17	PARAMED EDUCATION GENERAL 23	SUBTOTAL 24	
194.01	PRIVATE DUTY NURSING						17,636	194.01
194.02	PHYSICIAN REFERRAL CENTER						1,903	194.02
200	CROSS FOOT ADJUSTMENTS					1,978	1,978	200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)	1,538,806	824,807	466,810	53,052	1,978	22,140,966	202



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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	I&R COST & POST STEP-DOWN ADJS	TOTAL				
		25	26				
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS DEPARTMENT						4
5.01	COMMUNICATIONS						5.01
5.02	DATA PROCESSING						5.02
5.03	PURCHASING & STORES						5.03
5.04	ADMITTING						5.04
5.05	CASHIERING						5.05
5.06	ADMINISTRATIVE & GENERAL						5.06
6	MAINTENANCE & REPAIRS						6
6.01	CLINICAL ENGINEERING						6.01
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE						8
9	HOUSEKEEPING						9
10	DIETARY						10
11	CAFETERIA						11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION						13
14	CENTRAL SERVICES & SUPPLY						14
15	PHARMACY						15
16	MEDICAL RECORDS & LIBRARY						16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SERVICES-SALARY & FRINGES APPRVD						21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-PHARMACY RESIDENCY						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS		6,172,108				30
31	INTENSIVE CARE UNIT		754,801				31
40	SUBPROVIDER - IPF		411,882				40
43	NURSERY						43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM		3,927,856				50
51	RECOVERY ROOM		124,610				51
53	ANESTHESIOLOGY		159,357				53
54	RADIOLOGY-DIAGNOSTIC		2,272,382				54
54.01	ULTRASOUND		168,144				54.01
57	CT SCAN		429,392				57
58	MRI		390,501				58
59	CARDIAC CATHETERIZATION		456,077				59
60	LABORATORY		1,308,885				60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	BLOOD STORING, PROCESSING & TRANS.		61,461				63
64	INTRAVENOUS THERAPY		65,712				64
65	RESPIRATORY THERAPY		265,723				65
66	PHYSICAL THERAPY		420,748				66
68	SPEECH PATHOLOGY		6,087				68
69	ELECTROCARDIOLOGY		503,607				69
70	ELECTROENCEPHALOGRAPHY		38,120				70
70.01	EMG		16,805				70.01
70.03	ANGIOGRAPHY		163,827				70.03
71	MEDICAL SUPPLIES CHARGED TO PATIENTS		567,295				71
72	IMPL. DEV. CHARGED TO PATIENTS		160,414				72
73	DRUGS CHARGED TO PATIENTS		930,236				73
74	RENAL DIALYSIS		17,880				74
76.97	CARDIAC REHABILITATION		38,211				76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	OUTPATIENT PSYCHE SERVICES		29,081				90.01
91	EMERGENCY		997,686				91
91.01	PCC		322,794				91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
101	HOME HEALTH AGENCY		292,453				101
	SPECIAL PURPOSE COST CENTERS						
113	INTEREST EXPENSE						113
116	HOSPICE		386,078				116
118	SUBTOTALS (sum of lines 1-117)		21,860,213				118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN		33,628				190
192	PHYSICIANS' PRIVATE OFFICES		225,608				192
194	NEW DIRECTION						194



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ALLOCATION OF CAPITAL-RELATED COSTS

WORKSHEET B
PART II

	COST CENTER DESCRIPTIONS	I&R COST & POST STEP- DOWN ADJS	TOTAL					
		25	26					
194.01	PRIVATE DUTY NURSING		17,636					194.01
194.02	PHYSICIAN REFERRAL CENTER		1,903					194.02
200	CROSS FOOT ADJUSTMENTS		1,978					200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)		22,140,966					202



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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VALUE	EMPLOYEE BENEFITS DEPARTMENT FTES	COMMUNICATIONS # OF PHONES	DATA PROCESSING TIME SPENT	PURCH & STORES # OF REQUISIT.	
		1	2	4	5.01	5.02	5.03	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT	878,307						1
2	CAP REL COSTS-MVBLE EQUIP		12,510,907					2
4	EMPLOYEE BENEFITS DEPARTMENT	3,906	5,540	2,280				4
5.01	COMMUNICATIONS	1,551	258,225	11	2,771			5.01
5.02	DATA PROCESSING	8,708	3,541,939	43	110	2,103		5.02
5.03	PURCHASING & STORES	2,890	23,864	9	13	16	33,594	5.03
5.04	ADMITTING	1,595	2,892	53	31	53	47	5.04
5.05	CASHIERING	10,235	17,599	44	207	101	71	5.05
5.06	ADMINISTRATIVE & GENERAL	105,609	1,145,649	166	277	494	1,902	5.06
6	MAINTENANCE & REPAIRS	108,866	816,612	32	57		2,978	6
6.01	CLINICAL ENGINEERING	1,260	259,266	8	11	9	344	6.01
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE	4,706	863	3			551	8
9	HOUSEKEEPING	1,672	60,972	67	16		306	9
10	DIETARY	17,869	60,350	72	28	28	443	10
11	CAFETERIA	9,765						11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION	3,449	8,766	26	37	92	261	13
14	CENTRAL SERVICES & SUPPLY	37,329	868,243	46	56	20	4,267	14
15	PHARMACY	9,500	497,986	52	61	52	406	15
16	MEDICAL RECORDS & LIBRARY	6,846	7,618	53	50	172	127	16
17	SOCIAL SERVICE	1,351	328	13	16	10	60	17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-PHARMACY RESIDENCY	36		1	1			23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	257,350	191,535	524	455	465	1,495	30
31	INTENSIVE CARE UNIT	25,965	230,174	77	47		189	31
40	SUBPROVIDER - IPF	18,226	8,508	60	44	8	323	40
43	NURSERY							43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	81,880	1,752,392	121	218	86	2,650	50
51	RECOVERY ROOM	4,370	18,669	19	15	2	96	51
53	ANESTHESIOLOGY	1,042	80,422		14		242	53
54	RADIOLOGY-DIAGNOSTIC	20,839	785,586	94	108	94	1,748	54
54.01	ULTRASOUND	1,681	108,755	15			80	54.01
57	CT SCAN	2,033	299,882	17			70	57
58	MRI	1,730	349,695	5			24	58
59	CARDIAC CATHETERIZATION	12,213	131,215	23	33		4,849	59
60	LABORATORY	26,854	422,646	97	131	78	5,533	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.	1,071	6,858	8			204	63
64	INTRAVENOUS THERAPY	788	4,413	16	16		20	64
65	RESPIRATORY THERAPY	1,609	78,917	38	29	15	272	65
66	PHYSICAL THERAPY	13,717	18,059	64	60	37	1,095	66
68	SPEECH PATHOLOGY		1,194	3			12	68
69	ELECTROCARDIOLOGY	12,939	138,301	29	46	67	159	69
70	ELECTROENCEPHALOGRAPHY	983	6,154	2	4		9	70
70.01	EMG	221	9,137	3	10		56	70.01
70.03	ANGIOGRAPHY	1,224	120,912	7	3		717	70.03
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS	768				1	69	74
76.97	CARDIAC REHABILITATION		16,642	12			160	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT PSYCHE SERVICES		2,409	17			87	90.01
91	EMERGENCY	33,532	29,810	95	128	132	319	91
91.01	PCC		51,392	53	235	52	729	91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
101	HOME HEALTH AGENCY	720	69,267	114	86	19	582	101
	SPECIAL PURPOSE COST CENTERS							
116	HOSPICE	620	278	39			35	116
118	SUBTOTALS (sum of lines 1-117)	859,518	12,509,934	2,251	2,653	2,103	33,587	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN	2,399		2			2	190
192	PHYSICIANS' PRIVATE OFFICES	16,390	427		118			192
194	NEW DIRECTION							194



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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VALUE	EMPLOYEE BENEFITS DEPARTMENT FTES	COMMUNI- CATIONS # OF PHONES	DATA PROCESSING TIME SPENT	PURCH & STORES # OF REQUISIT.	
		1	2	4	5.01	5.02	5.03	
194.01	PRIVATE DUTY NURSING			25			4	194.01
194.02	PHYSICIAN REFERRAL CENTER		546	2			1	194.02
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	8,247,916	12,455,719	50,905,307	1,227,371	11,527,157	932,867	202
203	UNIT COST MULT-WS B PT I	9.390698	0.995589	22,326.889035	442.934320	5,481.291964	27.768858	203
204	COST TO BE ALLOC PER B PT II			42,196	271,855	3,619,697	80,953	204
205	UNIT COST MULT-WS B PT II			18,507018	98.107182	1,721.206372	2.409746	205



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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	ADMITTING BLDGS & FIXTURES INPATIENT REVENUES	CASHIERING MOVABLE EQUIPMENT INPATIENT REVENUES	EMPLOYEE RECON- CILIATION FTES	ADMINIS- TRATIVE & GENERAL ACCUM COST	MAIN- TENANCE & REPAIRS SQUARE FEET	CLINICAL ENGINEER TIME SPENT	
		5.04	5.05	5A.06	5.06	6	6.01	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.01	COMMUNICATIONS							5.01
5.02	DATA PROCESSING							5.02
5.03	PURCHASING & STORES							5.03
5.04	ADMITTING	648,490,164						5.04
5.05	CASHIERING		648,490,164					5.05
5.06	ADMINISTRATIVE & GENERAL			-29,564,387	274,734,085			5.06
6	MAINTENANCE & REPAIRS				8,916,481	634,947		6
6.01	CLINICAL ENGINEERING				1,203,448	1,260	7,650	6.01
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE				1,553,305	4,706		8
9	HOUSEKEEPING				5,306,555	1,672	8	9
10	DIETARY				5,150,910	17,869	1	10
11	CAFETERIA				1,072,030	9,765		11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION				3,488,527	3,449	283	13
14	CENTRAL SERVICES & SUPPLY				5,857,371	37,329	641	14
15	PHARMACY				6,838,822	9,500		15
16	MEDICAL RECORDS & LIBRARY				5,713,185	6,846		16
17	SOCIAL SERVICE				1,326,700	1,351		17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-PHARMACY RESIDENCY				110,807	36		23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	116,385,338	116,385,338		57,405,676	257,350	1,108	30
31	INTENSIVE CARE UNIT	16,182,112	16,182,112		8,575,232	25,965	222	31
40	SUBPROVIDER - IPF	13,612,385	13,612,385		6,239,220	18,226	30	40
43	NURSERY							43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	89,597,166	89,597,166		25,662,030	81,880	1,393	50
51	RECOVERY ROOM	7,032,214	7,032,214		2,081,457	4,370	113	51
53	ANESTHESIOLOGY	19,492,409	19,492,409		847,560	1,042	300	53
54	RADIOLOGY-DIAGNOSTIC	18,409,823	18,409,823		12,972,498	20,839	1,288	54
54.01	ULTRASOUND	8,171,186	8,171,186		2,041,031	1,681	57	54.01
57	CT SCAN	36,007,976	36,007,976		3,271,681	2,033	29	57
58	MRI	5,939,347	5,939,347		1,215,023	1,730	24	58
59	CARDIAC CATHETERIZATION	18,339,035	18,339,035		4,209,052	12,213	252	59
60	LABORATORY	98,036,939	98,036,939		15,535,200	26,854	329	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.	5,601,643	5,601,643		2,825,328	1,071	67	63
64	INTRAVENOUS THERAPY	834,473	834,473		1,918,282	788	1	64
65	RESPIRATORY THERAPY	35,798,807	35,798,807		4,662,875	1,609	516	65
66	PHYSICAL THERAPY	8,120,958	8,120,958		6,923,530	13,717	270	66
68	SPEECH PATHOLOGY	1,135,737	1,135,737		332,234			68
69	ELECTROCARDIOLOGY	19,213,863	19,213,863		3,553,046	12,939	249	69
70	ELECTROENCEPHALOGRAPHY	654,788	654,788		378,883	983	12	70
70.01	EMG	171,412	171,412		253,164	221	8	70.01
70.03	ANGIOGRAPHY	4,850,083	4,850,083		1,411,008	1,224	22	70.03
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	23,086,530	23,086,530		3,869,657			71
72	IMPL. DEV. CHARGED TO PATIENTS	20,365,193	20,365,193		12,834,157			72
73	DRUGS CHARGED TO PATIENTS	45,883,191	45,883,191		10,259,220			73
74	RENAL DIALYSIS	1,596,120	1,596,120		455,064	768	4	74
76.97	CARDIAC REHABILITATION	665,119	665,119		1,264,762		114	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT PSYCHE SERVICES	7,112	7,112		1,586,620		2	90.01
91	EMERGENCY	33,248,997	33,248,997		10,905,258	33,532	243	91
91.01	PCC	50,208	50,208		4,827,518		58	91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
101	HOME HEALTH AGENCY				12,535,983	720	6	101
	SPECIAL PURPOSE COST CENTERS							
116	HOSPICE				4,598,286	620		116
118	SUBTOTALS (sum of lines 1-117)	648,490,164	648,490,164	-29,564,387	271,988,676	616,158	7,650	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN				320,712	2,399		190
192	PHYSICIANS' PRIVATE OFFICES				812,701	16,390		192
194	NEW DIRECTION							194



COMPU-MAX

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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	ADMITTING BLDGS & FIXTURES INPATIENT REVENUES	CASHIERING MOVABLE EQUIPMENT INPATIENT REVENUES	EMPLOYEE RECON- CILIATION FTES	ADMINIS- TRATIVE & GENERAL ACCUM COST	MAIN- TENANCE & REPAIRS SQUARE FEET	CLINICAL ENGINEER TIME SPENT	
		5.04	5.05	5A.06	5.06	6	6.01	
194.01	PRIVATE DUTY NURSING				1,496,855			194.01
194.02	PHYSICIAN REFERRAL CENTER				115,141			194.02
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	4,023,149	5,216,700		29,564,387	9,875,992	1,352,550	202
203	UNIT COST MULT-WS B PT I	0.006204	0.008044		0.107611	15.554042	176.803922	203
204	COST TO BE ALLOC PER B PT II	113,216	308,770		3,149,970	1,951,479	305,173	204
205	UNIT COST MULT-WS B PT II	0.000175	0.000476		0.011466	3.073452	39.891895	205



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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	HOUSE-KEEPING EQUIPMENT HOURS OF SERVICE	DIETARY RECONCILIATION MEALS SERVED	CAFETERIA TRATIVE & GENERAL FTES COST	NURSING ADMINISTRATION FTES FEET	CENTRAL SERVICES & SUPPLY COSTED REQUIS.	
		8	9	10	11	13	14	
	GENERAL SERVICE COST CENTERS							
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.01	COMMUNICATIONS							5.01
5.02	DATA PROCESSING							5.02
5.03	PURCHASING & STORES							5.03
5.04	ADMITTING							5.04
5.05	CASHIERING							5.05
5.06	ADMINISTRATIVE & GENERAL							5.06
6	MAINTENANCE & REPAIRS							6
6.01	CLINICAL ENGINEERING							6.01
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE	2,303,392						8
9	HOUSEKEEPING	82,733	16,847					9
10	DIETARY	1,460	275	301,977				10
11	CAFETERIA				1,522			11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION		136		26	952		13
14	CENTRAL SERVICES & SUPPLY	13,505	394		46		9,878,274	14
15	PHARMACY	973	230		52		180,517	15
16	MEDICAL RECORDS & LIBRARY		159		53		497	16
17	SOCIAL SERVICE		35		13		325	17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-PHARMACY RESIDENCY		6		1			23
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	1,044,995	7,435	264,743	524	524	912,610	30
31	INTENSIVE CARE UNIT	134,685	733	4,872	77	77	148,052	31
40	SUBPROVIDER - IPF	50,005	626	23,961	60	60	20,942	40
43	NURSERY							43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	309,033	1,749		121	121	2,837,966	50
51	RECOVERY ROOM	33,823	206		19	19	19,285	51
53	ANESTHESIOLOGY		80				187,846	53
54	RADIOLOGY-DIAGNOSTIC	161,573	1,108		94		123,701	54
54.01	ULTRASOUND				15		18,582	54.01
57	CT SCAN				17		243,522	57
58	MRI				5		135	58
59	CARDIAC CATHETERIZATION	23,482	277		23	23	479,194	59
60	LABORATORY		440		97		549,788	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.				8		7,872	63
64	INTRAVENOUS THERAPY		31		16	16	133,096	64
65	RESPIRATORY THERAPY		95		38		127,147	65
66	PHYSICAL THERAPY	29,200	334		64		75,232	66
68	SPEECH PATHOLOGY				3			68
69	ELECTROCARDIOLOGY	50,127	145		29		62,009	69
70	ELECTROENCEPHALOGRAPHY	973	31		2		911	70
70.01	EMG				3		655	70.01
70.03	ANGIOGRAPHY				7		33,419	70.03
71	MEDICAL SUPPLIES CHARGED TO PATIENTS						3,260,414	71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS							73
74	RENAL DIALYSIS							74
76.97	CARDIAC REHABILITATION				12		377	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT PSYCHE SERVICES			1,578		17	266	90.01
91	EMERGENCY	264,017	1,880	6,823	95	95	209,475	91
91.01	PCC	102,808	442				79,727	91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
101	HOME HEALTH AGENCY				2		162,181	101
	SPECIAL PURPOSE COST CENTERS							
116	HOSPICE						2,477	116
118	SUBTOTALS (sum of lines 1-117)	2,303,392	16,847	301,977	1,522	952	9,878,220	118
	NONREIMBURSABLE COST CENTERS							
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN						54	190
192	PHYSICIANS' PRIVATE OFFICES							192
194	NEW DIRECTION							194



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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	HOUSE-KEEPING EQUIPMENT HOURS OF SERVICE	DIETARY RECON-CILIATION MEALS SERVED	CAFETERIA TRATIVE & GENERAL FTES COST	NURSING ADMINIS-TRATION FTES FEET	CENTRAL SERVICES & SUPPLY COSTED REQUIS.	
		8	9	10	11	13	14	
194.01	PRIVATE DUTY NURSING							194.01
194.02	PHYSICIAN REFERRAL CENTER							194.02
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	1,793,655	5,969,443	6,081,895	1,339,277	4,038,681	7,372,237	202
203	UNIT COST MULT-WS B PT I	0.778702	354.332700	20.140259	879.945466	4,242.311975	0.746308	203
204	COST TO BE ALLOC PER B PT II	78.710	149.081	402.820	134,004	273.012	1,538,806	204
205	UNIT COST MULT-WS B PT II	0.034171	8.849113	1.333943	88.044678	286.777311	0.155777	205



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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	PHARMACY & LINEN SERVICE COSTED REQUIS.	MEDICAL RECORDS & LIBRARY TIME SPENT	SOCIAL SERVICE CILATION TIME SPENT	PARAMED EDUCATION GENERAL ASSIGNED TIME			
		15	16	17	23			

GENERAL SERVICE COST CENTERS								
1	CAP REL COSTS-BLDG & FIXT							1
2	CAP REL COSTS-MVBLE EQUIP							2
4	EMPLOYEE BENEFITS DEPARTMENT							4
5.01	COMMUNICATIONS							5.01
5.02	DATA PROCESSING							5.02
5.03	PURCHASING & STORES							5.03
5.04	ADMITTING							5.04
5.05	CASHIERING							5.05
5.06	ADMINISTRATIVE & GENERAL							5.06
6	MAINTENANCE & REPAIRS							6
6.01	CLINICAL ENGINEERING							6.01
7	OPERATION OF PLANT							7
8	LAUNDRY & LINEN SERVICE							8
9	HOUSEKEEPING							9
10	DIETARY							10
11	CAFETERIA							11
12	MAINTENANCE OF PERSONNEL							12
13	NURSING ADMINISTRATION							13
14	CENTRAL SERVICES & SUPPLY							14
15	PHARMACY	8,954,140						15
16	MEDICAL RECORDS & LIBRARY		4,339					16
17	SOCIAL SERVICE			990				17
19	NONPHYSICIAN ANESTHETISTS							19
20	NURSING SCHOOL							20
21	I&R SERVICES-SALARY & FRINGES APPRVD							21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD							22
23	PARAMED ED PRGM-PHARMACY RESIDENCY					100		23
INPATIENT ROUTINE SERV COST CENTERS								
30	ADULTS & PEDIATRICS	9,071	2,699	862				30
31	INTENSIVE CARE UNIT	225	50	54				31
40	SUBPROVIDER - IPF	36	87					40
43	NURSERY							43
ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	1,036	317					50
51	RECOVERY ROOM	9						51
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC	32,025	113					54
54.01	ULTRASOUND	75	30					54.01
57	CT SCAN	2,600	30					57
58	MRI	229	13					58
59	CARDIAC CATHETERIZATION	11,873						59
60	LABORATORY	312	353					60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.							63
64	INTRAVENOUS THERAPY							64
65	RESPIRATORY THERAPY		3					65
66	PHYSICAL THERAPY	386	18					66
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY	144	51					69
70	ELECTROENCEPHALOGRAPHY		2					70
70.01	EMG	893						70.01
70.03	ANGIOGRAPHY	29						70.03
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS	8,497,416				100		73
74	RENAL DIALYSIS	41						74
76.97	CARDIAC REHABILITATION	51	4					76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
OUTPATIENT SERVICE COST CENTERS								
90.01	OUTPATIENT PSYCHE SERVICES		8					90.01
91	EMERGENCY	6,991	407	74				91
91.01	PCC	30,633	154					91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
OTHER REIMBURSABLE COST CENTERS								
101	HOME HEALTH AGENCY	4,870						101
SPECIAL PURPOSE COST CENTERS								
116	HOSPICE	355,195						116
118	SUBTOTALS (sum of lines 1-117)	8,954,140	4,339	990	100			118
NONREIMBURSABLE COST CENTERS								
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN							190



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COST ALLOCATION - STATISTICAL BASIS

WORKSHEET B-1

	COST CENTER DESCRIPTIONS	PHARMACY & LINEN SERVICE COSTED REQUIS.	MEDICAL RECORDS & LIBRARY TIME SPENT	SOCIAL SERVICE CILIATION TIME SPENT	PARAMED EDUCATION GENERAL ASSIGNED TIME			
		15	16	17	23			
192	PHYSICIANS' PRIVATE OFFICES							192
194	NEW DIRECTION							194
194.01	PRIVATE DUTY NURSING							194.01
194.02	PHYSICIAN REFERRAL CENTER							194.02
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	COST TO BE ALLOC PER B PT I	7,985,250	6,537,817	1,514,566	126,297			202
203	UNIT COST MULT-WS B PT I	0.891794	1,506.756626	1,529.864646	1,262.970000			203
204	COST TO BE ALLOC PER B PT II	824,807	466,810	53,052	1,978			204
205	UNIT COST MULT-WS B PT II	0.092115	107.584697	53.587879	19.780000			205



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POST STEPDOWN ADJUSTMENTS

WORKSHEET B-2

	DESCRIPTION	WORKSHEET		
		PART	LINE NO.	AMOUNT
	1	2	3	4



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COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

	COST CENTER DESCRIPTIONS	COSTS					
		TOTAL COST (from Wkst. B, Part I, col. 26)	THERAPY LIMIT ADJ.	TOTAL COSTS	RCE DISALLOW- ANCE	TOTAL COSTS	
		1	2	3	4	5	
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS	85,320,778		85,320,778	105,549	85,426,327	30
31	INTENSIVE CARE UNIT	11,066,918		11,066,918	1,983	11,068,901	31
40	SUBPROVIDER - IPF	8,396,838		8,396,838		8,396,838	40
43	NURSERY						43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	34,020,129		34,020,129		34,020,129	50
51	RECOVERY ROOM	2,604,450		2,604,450		2,604,450	51
53	ANESTHESIOLOGY	1,176,553		1,176,553	81,807	1,258,360	53
54	RADIOLOGY-DIAGNOSTIC	15,812,610		15,812,610		15,812,610	54
54.01	ULTRASOUND	2,369,229		2,369,229		2,369,229	54.01
57	CT SCAN	3,904,721		3,904,721		3,904,721	57
58	MRI	1,401,217		1,401,217		1,401,217	58
59	CARDIAC CATHETERIZATION	5,498,970		5,498,970	14,777	5,513,747	59
60	LABORATORY	18,866,549		18,866,549		18,866,549	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	BLOOD STORING, PROCESSING & TRANS.	3,170,783		3,170,783		3,170,783	63
64	INTRAVENOUS THERAPY	2,329,415		2,329,415		2,329,415	64
65	RESPIRATORY THERAPY	5,447,420		5,447,420	22,408	5,469,828	65
66	PHYSICAL THERAPY	8,210,684		8,210,684	66,781	8,277,465	66
68	SPEECH PATHOLOGY	370,626		370,626		370,626	68
69	ELECTROCARDIOLOGY	4,419,852		4,419,852		4,419,852	69
70	ELECTROENCEPHALOGRAPHY	454,263		454,263		454,263	70
70.01	EMG	289,183		289,183		289,183	70.01
70.03	ANGIOGRAPHY	1,616,903		1,616,903		1,616,903	70.03
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	6,719,349		6,719,349		6,719,349	71
72	IMPL. DEV. CHARGED TO PATIENTS	14,215,253		14,215,253		14,215,253	72
73	DRUGS CHARGED TO PATIENTS	19,067,469		19,067,469		19,067,469	73
74	RENAL DIALYSIS	516,724		516,724		516,724	74
76.97	CARDIAC REHABILITATION	1,437,932		1,437,932		1,437,932	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	OUTPATIENT PSYCHE SERVICES	1,873,865		1,873,865		1,873,865	90.01
91	EMERGENCY	15,028,101		15,028,101		15,028,101	91
91.01	PCC	5,912,799		5,912,799		5,912,799	91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)	9,846,549		9,846,549		9,846,549	92
	OTHER REIMBURSABLE COST CENTERS						
101	HOME HEALTH AGENCY	14,024,393		14,024,393		14,024,393	101
113	INTEREST EXPENSE						113
116	HOSPICE	5,421,366		5,421,366		5,421,366	116
200	SUBTOTAL (SEE INSTRUCTIONS)	310,811,891		310,811,891	293,305	311,105,196	200
201	LESS OBSERVATION BEDS	9,846,549		9,846,549		9,846,549	201
202	TOTAL (SEE INSTRUCTIONS)	300,965,342		300,965,342		301,258,647	202



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COMPUTATION OF RATIO OF COST TO CHARGES

WORKSHEET C
PART I

	COST CENTER DESCRIPTIONS	CHARGES			COST OR OTHER RATIO	TEFRA INPATIENT RATIO	PPS INPATIENT RATIO	
		INPATIENT	OUTPATIENT	TOTAL (column 6 + column 7)				
		6	7	8	9	10	11	
	INPATIENT ROUTINE SERV COST CENTERS							
30	ADULTS & PEDIATRICS	116,385,338		116,385,338				30
31	INTENSIVE CARE UNIT	16,182,112		16,182,112				31
40	SUBPROVIDER - IPF	13,612,385		13,612,385				40
43	NURSERY							43
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	89,597,166	101,199,027	190,796,193	0.178306	0.178306	0.178306	50
51	RECOVERY ROOM	7,032,214	5,140,696	12,172,910	0.213955	0.213955	0.213955	51
53	ANESTHESIOLOGY	19,492,409	15,460,534	34,952,943	0.033661	0.033661	0.036002	53
54	RADIOLOGY-DIAGNOSTIC	18,409,823	59,092,086	77,501,909	0.204029	0.204029	0.204029	54
54.01	ULTRASOUND	8,171,186	14,606,761	22,777,947	0.104014	0.104014	0.104014	54.01
57	CT SCAN	36,007,976	76,322,094	112,330,070	0.034761	0.034761	0.034761	57
58	MRI	5,939,347	9,128,012	15,067,359	0.092997	0.092997	0.092997	58
59	CARDIAC CATHETERIZATION	18,339,035	14,700,982	33,040,017	0.166434	0.166434	0.166881	59
60	LABORATORY	98,036,939	100,336,896	198,373,835	0.095106	0.095106	0.095106	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.	5,601,643	2,292,831	7,894,474	0.401646	0.401646	0.401646	63
64	INTRAVENOUS THERAPY	834,473	6,796,584	7,631,057	0.305255	0.305255	0.305255	64
65	RESPIRATORY THERAPY	35,798,807	4,949,086	40,747,893	0.133686	0.133686	0.134236	65
66	PHYSICAL THERAPY	8,120,958	15,473,843	23,594,801	0.347987	0.347987	0.350817	66
68	SPEECH PATHOLOGY	1,135,737	660,386	1,796,123	0.206348	0.206348	0.206348	68
69	ELECTROCARDIOLOGY	19,213,863	23,017,811	42,231,674	0.104657	0.104657	0.104657	69
70	ELECTROENCEPHALOGRAPHY	654,788	1,557,510	2,212,298	0.205335	0.205335	0.205335	70
70.01	EMG	171,412	2,189,841	2,361,253	0.122470	0.122470	0.122470	70.01
70.03	ANGIOGRAPHY	4,850,083	2,122,527	6,972,610	0.231894	0.231894	0.231894	70.03
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	23,086,530	10,760,379	33,846,909	0.198522	0.198522	0.198522	71
72	IMPL. DEV. CHARGED TO PATIENTS	20,365,193	6,211,873	26,577,066	0.534869	0.534869	0.534869	72
73	DRUGS CHARGED TO PATIENTS	45,883,191	11,213,180	57,096,371	0.333952	0.333952	0.333952	73
74	RENAL DIALYSIS	1,596,120	113,200	1,709,320	0.302298	0.302298	0.302298	74
76.97	CARDIAC REHABILITATION	665,119	2,676,582	3,341,701	0.430299	0.430299	0.430299	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT PSYCHE SERVICES	7,112	5,441,317	5,448,429	0.343928	0.343928	0.343928	90.01
91	EMERGENCY	33,248,997	64,329,820	97,578,817	0.154010	0.154010	0.154010	91
91.01	PCC	50,208	6,983,636	7,033,844	0.840621	0.840621	0.840621	91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)	2,979,268	14,650,699	17,629,967	0.558512	0.558512	0.558512	92
	OTHER REIMBURSABLE COST CENTERS							
101	HOME HEALTH AGENCY		15,172,868	15,172,868				101
113	INTEREST EXPENSE							113
116	HOSPICE		9,050,126	9,050,126				116
200	SUBTOTAL (SEE INSTRUCTIONS)	651,469,432	601,651,187	1,253,120,619				200
201	LESS OBSERVATION BEDS							201
202	TOTAL (SEE INSTRUCTIONS)	651,469,432	601,651,187	1,253,120,619				202



COMPU-MAX

PALOS COMMUNITY HOSPITAL Provider CCN: 14-0062	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 08:45 Version: 2014.03
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

CHECK TITLE V PPS
 APPLICABLE TITLE XVIII, PART A TEFRA
 BOXES: TITLE XIX

		CAPITAL RELATED COST (from Wkst. B, Part II, (col. 26)	SWING BED ADJUSTMENT	REDUCED CAPITAL RELATED COST (col. 1 minus col. 2)	TOTAL PATIENT DAYS	PER DIEM (col. 3 ÷ col. 4)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM CAPITAL COST (col. 5 x col. 6)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERV COST CENTERS								
30	ADULTS & PEDIATRICS (General Routine Care)	6,172,108		6,172,108	75,384	81.88	42,629	3,490,463	30
31	INTENSIVE CARE UNIT	754,801		754,801	5,772	130.77	4,690	613,311	31
32	CORONARY CARE UNIT								32
33	BURN INTENSIVE CARE UNIT								33
34	SURGICAL INTENSIVE CARE UNIT								34
35	OTHER SPECIAL CARE (SPECIFY)								35
40	SUBPROVIDER - IPF	411,882		411,882	6,694	61.53	2,336	143,734	40
41	SUBPROVIDER - IRF								41
42	SUBPROVIDER I								42
43	NURSERY				2,141				43
44	SKILLED NURSING FACILITY								44
45	NURSING FACILITY								45
200	TOTAL (lines 30-199)	7,338,791		7,338,791	89,991		49,655	4,247,508	200

(A) Worksheet A line numbers



COMPU-MAX

PALOS COMMUNITY HOSPITAL Provider CCN: 14-0062	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 08:45 Version: 2014.03
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-0062

WORKSHEET D
PART II

CHECK [] TITLE V [XX] HOSPITAL [] SUB (OTHER) [XX] PPS
 APPLICABLE [XX] TITLE XVIII, PART A [] IPF [] TEFRA
 BOXES: [] TITLE XIX [] IRF

(A)	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 (col. 3 x col. 4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	3,927,856	190,796,193	0.020587	48,808,134	1,004,813	50
51	RECOVERY ROOM	124,610	12,172,910	0.010237	3,793,045	38,829	51
53	ANESTHESIOLOGY	159,357	34,952,943	0.004559	10,031,384	45,733	53
54	RADIOLOGY-DIAGNOSTIC	2,272,382	77,501,909	0.029320	13,274,261	389,201	54
54.01	ULTRASOUND	168,144	22,777,947	0.007382	5,716,454	42,199	54.01
57	CT SCAN	429,392	112,330,070	0.003823	23,373,317	89,356	57
58	MRI	390,501	15,067,359	0.025917	3,696,049	95,791	58
59	CARDIAC CATHETERIZATION	456,077	33,040,017	0.013804	11,463,851	158,247	59
60	LABORATORY	1,308,885	198,373,835	0.006598	64,340,552	424,519	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	BLOOD STORING, PROCESSING & TRANS.	61,461	7,894,474	0.007785	3,739,415	29,111	63
64	INTRAVENOUS THERAPY	65,712	7,631,057	0.008611	600,906	5,174	64
65	RESPIRATORY THERAPY	265,723	40,747,893	0.006521	26,764,541	174,532	65
66	PHYSICAL THERAPY	420,748	23,594,801	0.017832	6,219,769	110,911	66
68	SPEECH PATHOLOGY	6,087	1,796,123	0.003389	971,842	3,294	68
69	ELECTROCARDIOLOGY	503,607	42,231,674	0.011925	13,684,950	163,193	69
70	ELECTROENCEPHALOGRAPHY	38,120	2,212,298	0.017231	413,580	7,126	70
70.01	EMG	16,805	2,361,253	0.007117	131,053	933	70.01
70.03	ANGIOGRAPHY	163,827	6,972,610	0.023496	3,695,380	86,827	70.03
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	567,295	33,846,909	0.016761	14,495,452	242,958	71
72	IMPL. DEV. CHARGED TO PATIENTS	160,414	26,577,066	0.006036	11,888,931	71,762	72
73	DRUGS CHARGED TO PATIENTS	930,236	57,096,371	0.016292	29,422,104	479,345	73
74	RENAL DIALYSIS	17,880	1,709,320	0.010460	1,194,316	12,493	74
76.97	CARDIAC REHABILITATION	38,211	3,341,701	0.011435	456,275	5,218	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	OUTPATIENT PSYCHE SERVICES	29,081	5,448,429	0.005338	6,806	36	90.01
91	EMERGENCY	997,686	97,578,817	0.010224	20,500,432	209,596	91
91.01	PCC	322,794	7,033,844	0.045892	47,443	2,177	91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)	711,423	17,629,967	0.040353	2,329,823	94,015	92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (sum of lines 50-199)	14,554,314	1,082,717,790		321,060,065	3,987,389	200

(A) Worksheet A line numbers



COMPU-MAX

PALOS COMMUNITY HOSPITAL Provider CCN: 14-0062	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 08:45 Version: 2014.03
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

CHECK TITLE V PPS
 APPLICABLE TITLE XVIII, PART A TEFRA
 BOXES: TITLE XIX

		NURSING SCHOOL	ALLIED HEALTH COST	ALL OTHER MEDICAL EDUCATION COST	SWING-BED ADJUSTMENT AMOUNT (see instructions)	TOTAL COSTS (sum of cols. 1 through 3 minus col 4.)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS (General Routine Care)						30
31	INTENSIVE CARE UNIT						31
32	CORONARY CARE UNIT						32
33	BURN INTENSIVE CARE UNIT						33
34	SURGICAL INTENSIVE CARE UNIT						34
35	OTHER SPECIAL CARE (SPECIFY)						35
40	SUBPROVIDER - IPF						40
41	SUBPROVIDER - IRF						41
42	SUBPROVIDER I						42
43	NURSERY						43
44	SKILLED NURSING FACILITY						44
45	NURSING FACILITY						45
200	TOTAL (lines 30-199)						200

(A) Worksheet A line numbers



PALOS COMMUNITY HOSPITAL Provider CCN: 14-0062	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 08:45 Version: 2014.03
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

CHECK TITLE V PPS
 APPLICABLE TITLE XVIII, PART A TEFRA
 BOXES: TITLE XIX

		TOTAL PATIENT DAYS	PER DIEM (col. 5 ÷ col. 6)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM PASS THRU COST (col. 7 x col. 8)	
(A)	COST CENTER DESCRIPTION	6	7	8	9	
	INPATIENT ROUTINE SERV COST CENTERS					
30	ADULTS & PEDIATRICS (General Routine Care)	75,384		42,629		30
31	INTENSIVE CARE UNIT	5,772		4,690		31
32	CORONARY CARE UNIT					32
33	BURN INTENSIVE CARE UNIT					33
34	SURGICAL INTENSIVE CARE UNIT					34
35	OTHER SPECIAL CARE (SPECIFY)					35
40	SUBPROVIDER - IPF	6,694		2,336		40
41	SUBPROVIDER - IRF					41
42	SUBPROVIDER I					42
43	NURSERY	2,141				43
44	SKILLED NURSING FACILITY					44
45	NURSING FACILITY					45
200	TOTAL (lines 30-199)	89,991		49,655		200

(A) Worksheet A line numbers



COMPU-MAX

PALOS COMMUNITY HOSPITAL Provider CCN: 14-0062	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 08:45 Version: 2014.03
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-0062

WORKSHEET D
PART IV

CHECK [] TITLE V [XX] HOSPITAL [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [XX] TITLE XVIII, PART A [] IPF [] SNF [] TEFRA
 BOXES: [] TITLE XIX [] IRF [] NF

(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
51	RECOVERY ROOM							51
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
54.01	ULTRASOUND							54.01
57	CT SCAN							57
58	MRI							58
59	CARDIAC CATHETERIZATION							59
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.							63
64	INTRAVENOUS THERAPY							64
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY							69
70	ELECTROENCEPHALOGRAPHY							70
70.01	EMG							70.01
70.03	ANGIOGRAPHY							70.03
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS			126,297		126,297	126,297	73
74	RENAL DIALYSIS							74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT PSYCHE SERVICES							90.01
91	EMERGENCY							91
91.01	PCC							91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (sum of lines 50-199)			126,297		126,297	126,297	200

(A) Worksheet A line numbers



COMPU-MAX

PALOS COMMUNITY HOSPITAL Provider CCN: 14-0062	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 08:45 Version: 2014.03
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-0062

WORKSHEET D
PART IV

CHECK [] TITLE V [XX] HOSPITAL [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [XX] TITLE XVIII, PART A [] IPF [] SNF [] TEFRA
 BOXES: [] TITLE XIX [] IRF [] NF

(A)	COST CENTER DESCRIPTION	TOTAL CHARGES (from Wkst. C, Part I, col. 8)	RATIO OF COST TO CHARGES (col. 5÷ col. 7)	OUTPAT-IENT RATIO OF COST TO CHARGES (col. 6÷ col. 7)	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM PASS-THROUGH COSTS (col. 8 x col. 10)	OUTPAT-IENT PROGRAM CHARGES	OUTPAT-IENT PROGRAM PASS-THROUGH COSTS (col. 9 x col. 12)
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	190,796,193			48,808,134		32,124,204	50
51	RECOVERY ROOM	12,172,910			3,793,045		1,280,024	51
53	ANESTHESIOLOGY	34,952,943			10,031,384		4,506,018	53
54	RADIOLOGY-DIAGNOSTIC	77,501,909			13,274,261		19,675,830	54
54.01	ULTRASOUND	22,777,947			5,716,454		4,830,824	54.01
57	CT SCAN	112,330,070			23,373,317		28,092,591	57
58	MRI	15,067,359			3,696,049		3,229,580	58
59	CARDIAC CATHETERIZATION	33,040,017			11,463,851		6,830,330	59
60	LABORATORY	198,373,835			64,340,552		11,003,721	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.	7,894,474			3,739,415		1,179,624	63
64	INTRAVENOUS THERAPY	7,631,057			600,906		2,595,873	64
65	RESPIRATORY THERAPY	40,747,893			26,764,541		2,325,418	65
66	PHYSICAL THERAPY	23,594,801			6,219,769			66
68	SPEECH PATHOLOGY	1,796,123			971,842			68
69	ELECTROCARDIOLOGY	42,231,674			13,684,950		8,375,339	69
70	ELECTROENCEPHALOGRAPHY	2,212,298			413,580		600,055	70
70.01	EMG	2,361,253			131,053		800,790	70.01
70.03	ANGIOGRAPHY	6,972,610			3,695,380		1,237,522	70.03
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	33,846,909			14,495,452		3,555,369	71
72	IMPL. DEV. CHARGED TO PATIENTS	26,577,066			11,888,931		2,430,148	72
73	DRUGS CHARGED TO PATIENTS	57,096,371	0.002212	0.002212	29,422,104	65,082	4,618,654	10,216
74	RENAL DIALYSIS	1,709,320			1,194,316		74,547	74
76.97	CARDIAC REHABILITATION	3,341,701			456,275		1,241,068	76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT PSYCHE SERVICES	5,448,429			6,806			90.01
91	EMERGENCY	97,578,817			20,500,432		16,848,811	91
91.01	PCC	7,033,844			47,443		1,065,677	91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)	17,629,967			2,329,823		5,516,471	92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (sum of lines 50-199)	1,082,717,790			321,060,065	65,082	164,038,488	10,216

(A) Worksheet A line numbers



COMPU-MAX

PALOS COMMUNITY HOSPITAL Provider CCN: 14-0062	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 08:45 Version: 2014.03
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-0062

WORKSHEET D
PART V

CHECK [] TITLE V - O/P [XX] HOSPITAL [] SUB (OTHER) [] SWING BED SNF
 APPLICABLE [XX] TITLE XVIII, PART B [] IPF [] SNF [] SWING BED NF
 BOXES: [] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

(A)	COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COST			
		COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PPS REIM-BURSED SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	PPS SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	
		1	2	3	4	5	6	7	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	0.178306	32,124,204			5,727,938			50
51	RECOVERY ROOM	0.213955	1,280,024			273,868			51
53	ANESTHESIOLOGY	0.033661	4,506,018			151,677			53
54	RADIOLOGY-DIAGNOSTIC	0.204029	19,675,830			4,014,440			54
54.01	ULTRASOUND	0.104014	4,830,824			502,473			54.01
57	CT SCAN	0.034761	28,092,591			976,527			57
58	MRI	0.092997	3,229,580			300,341			58
59	CARDIAC CATHETERIZATION	0.166434	6,830,330			1,136,799			59
60	LABORATORY	0.095106	11,003,721		9,100	1,046,520		865	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	BLOOD STORING, PROCESSING & TRANS.	0.401646	1,179,624			473,791			63
64	INTRAVENOUS THERAPY	0.305255	2,595,873			792,403			64
65	RESPIRATORY THERAPY	0.133686	2,325,418			310,876			65
66	PHYSICAL THERAPY	0.347987							66
68	SPEECH PATHOLOGY	0.206348							68
69	ELECTROCARDIOLOGY	0.104657	8,375,339			876,538			69
70	ELECTROENCEPHALOGRAPHY	0.205335	600,055			123,212			70
70.01	EMG	0.122470	800,790			98,073			70.01
70.03	ANGIOGRAPHY	0.231894	1,237,522			286,974			70.03
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.198522	3,555,369			705,819			71
72	IMPL. DEV. CHARGED TO PATIENTS	0.534869	2,430,148			1,299,811			72
73	DRUGS CHARGED TO PATIENTS	0.333952	4,618,654		275,674	1,542,409		92,062	73
74	RENAL DIALYSIS	0.302298	74,547			22,535			74
76.97	CARDIAC REHABILITATION	0.430299	1,241,068			534,030			76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.01	OUTPATIENT PSYCHE SERVICES	0.343928							90.01
91	EMERGENCY	0.154010	16,848,811			2,594,885			91
91.01	PCC	0.840621	1,065,677			895,830			91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.558512	5,516,471			3,081,015			92
	OTHER REIMBURSABLE COST CENTERS								
200	SUBTOTAL (see instructions)		164,038,488		284,774	27,768,784		92,927	200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES								201
202	NET CHARGES (line 200 - line 201)		164,038,488		284,774	27,768,784		92,927	202

(A) Worksheet A line numbers



COMPU-MAX

PALOS COMMUNITY HOSPITAL Provider CCN: 14-0062	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 08:45 Version: 2014.03
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-S062

WORKSHEET D
PART II

CHECK [] TITLE V [] HOSPITAL [] SUB (OTHER) [XX] PPS
 APPLICABLE [XX] TITLE XVIII, PART A [XX] IPF [] TEFRA
 BOXES: [] TITLE XIX [] IRF

(A)	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 (col. 3 x col. 4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	3,927,856	190,796,193	0.020587	37,060	763	50
51	RECOVERY ROOM	124,610	12,172,910	0.010237	610	6	51
53	ANESTHESIOLOGY	159,357	34,952,943	0.004559	5,415	25	53
54	RADIOLOGY-DIAGNOSTIC	2,272,382	77,501,909	0.029320	70,616	2,070	54
54.01	ULTRASOUND	168,144	22,777,947	0.007382	35,635	263	54.01
57	CT SCAN	429,392	112,330,070	0.003823	238,499	912	57
58	MRI	390,501	15,067,359	0.025917	51,718	1,340	58
59	CARDIAC CATHETERIZATION	456,077	33,040,017	0.013804			59
60	LABORATORY	1,308,885	198,373,835	0.006598	1,149,636	7,585	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	BLOOD STORING, PROCESSING & TRANS.	61,461	7,894,474	0.007785			63
64	INTRAVENOUS THERAPY	65,712	7,631,057	0.008611	3,893	34	64
65	RESPIRATORY THERAPY	265,723	40,747,893	0.006521	123,109	803	65
66	PHYSICAL THERAPY	420,748	23,594,801	0.017832	80,870	1,442	66
68	SPEECH PATHOLOGY	6,087	1,796,123	0.003389	8,882	30	68
69	ELECTROCARDIOLOGY	503,607	42,231,674	0.011925	75,335	898	69
70	ELECTROENCEPHALOGRAPHY	38,120	2,212,298	0.017231	22,983	396	70
70.01	EMG	16,805	2,361,253	0.007117	8,666	62	70.01
70.03	ANGIOGRAPHY	163,827	6,972,610	0.023496			70.03
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	567,295	33,846,909	0.016761	68,371	1,146	71
72	IMPL. DEV. CHARGED TO PATIENTS	160,414	26,577,066	0.006036			72
73	DRUGS CHARGED TO PATIENTS	930,236	57,096,371	0.016292	356,920	5,815	73
74	RENAL DIALYSIS	17,880	1,709,320	0.010460	7,075	74	74
76.97	CARDIAC REHABILITATION	38,211	3,341,701	0.011435			76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	OUTPATIENT PSYCHE SERVICES	29,081	5,448,429	0.005338			90.01
91	EMERGENCY	997,686	97,578,817	0.010224	722,450	7,386	91
91.01	PCC	322,794	7,033,844	0.045892	253	12	91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)		17,629,967				92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (sum of lines 50-199)	13,842,891	1,082,717,790		3,067,996	31,062	200

(A) Worksheet A line numbers



COMPU-MAX

PALOS COMMUNITY HOSPITAL Provider CCN: 14-0062	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 08:45 Version: 2014.03
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
 OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-S062

WORKSHEET D
 PART IV

CHECK [] TITLE V [] HOSPITAL [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [XX] TITLE XVIII, PART A [XX] IPF [] SNF [] TEFRA
 BOXES: [] TITLE XIX [] IRF [] NF

(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
51	RECOVERY ROOM							51
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
54.01	ULTRASOUND							54.01
57	CT SCAN							57
58	MRI							58
59	CARDIAC CATHETERIZATION							59
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.							63
64	INTRAVENOUS THERAPY							64
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY							69
70	ELECTROENCEPHALOGRAPHY							70
70.01	EMG							70.01
70.03	ANGIOGRAPHY							70.03
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS			126,297		126,297	126,297	73
74	RENAL DIALYSIS							74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT PSYCHE SERVICES							90.01
91	EMERGENCY							91
91.01	PCC							91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (sum of lines 50-199)			126,297		126,297	126,297	200

(A) Worksheet A line numbers



COMPU-MAX

PALOS COMMUNITY HOSPITAL Provider CCN: 14-0062	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 08:45 Version: 2014.03
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
 OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-S062

WORKSHEET D
 PART IV

CHECK [] TITLE V [] HOSPITAL [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [XX] TITLE XVIII, PART A [XX] IPF [] SNF [] TEFRA
 BOXES: [] TITLE XIX [] IRF [] NF

(A)	COST CENTER DESCRIPTION	TOTAL CHARGES (from Wkst. C, Part I, col. 8)	RATIO OF COST TO CHARGES (col. 5÷ col. 7)	OUTPAT-IENT RATIO OF COST TO CHARGES (col. 6÷ col. 7)	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM PASS-THROUGH COSTS (col. 8 x col. 10)	OUTPAT-IENT PROGRAM CHARGES	OUTPAT-IENT PROGRAM PASS-THROUGH COSTS (col. 9 x col. 12)
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	190,796,193			37,060			50
51	RECOVERY ROOM	12,172,910			610			51
53	ANESTHESIOLOGY	34,952,943			5,415			53
54	RADIOLOGY-DIAGNOSTIC	77,501,909			70,616			54
54.01	ULTRASOUND	22,777,947			35,635			54.01
57	CT SCAN	112,330,070			238,499			57
58	MRI	15,067,359			51,718			58
59	CARDIAC CATHETERIZATION	33,040,017						59
60	LABORATORY	198,373,835			1,149,636			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.	7,894,474						63
64	INTRAVENOUS THERAPY	7,631,057			3,893			64
65	RESPIRATORY THERAPY	40,747,893			123,109			65
66	PHYSICAL THERAPY	23,594,801			80,870			66
68	SPEECH PATHOLOGY	1,796,123			8,882			68
69	ELECTROCARDIOLOGY	42,231,674			75,335			69
70	ELECTROENCEPHALOGRAPHY	2,212,298			22,983			70
70.01	EMG	2,361,253			8,666			70.01
70.03	ANGIOGRAPHY	6,972,610						70.03
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	33,846,909			68,371			71
72	IMPL. DEV. CHARGED TO PATIENTS	26,577,066						72
73	DRUGS CHARGED TO PATIENTS	57,096,371	0.002212	0.002212	356,920	790		73
74	RENAL DIALYSIS	1,709,320			7,075			74
76.97	CARDIAC REHABILITATION	3,341,701						76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT PSYCHE SERVICES	5,448,429						90.01
91	EMERGENCY	97,578,817			722,450			91
91.01	PCC	7,033,844			253			91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)	17,629,967						92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (sum of lines 50-199)	1,082,717,790			3,067,996	790		200

(A) Worksheet A line numbers



COMPU-MAX

PALOS COMMUNITY HOSPITAL Provider CCN: 14-0062	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 08:45 Version: 2014.03
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-S062

WORKSHEET D
PART V

CHECK [] TITLE V - O/P [] HOSPITAL [] SUB (OTHER) [] SWING BED SNF
 APPLICABLE [XX] TITLE XVIII, PART B [XX] IPF [] SNF [] SWING BED NF
 BOXES: [] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

(A)	COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COST		
		COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PPS REIM-BURSED SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	PPS SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)
		1	2	3	4	5	6	7
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	0.178306						50
51	RECOVERY ROOM	0.213955						51
53	ANESTHESIOLOGY	0.033661						53
54	RADIOLOGY-DIAGNOSTIC	0.204029						54
54.01	ULTRASOUND	0.104014						54.01
57	CT SCAN	0.034761						57
58	MRI	0.092997						58
59	CARDIAC CATHETERIZATION	0.166434						59
60	LABORATORY	0.095106						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.	0.401646						63
64	INTRAVENOUS THERAPY	0.305255						64
65	RESPIRATORY THERAPY	0.133686						65
66	PHYSICAL THERAPY	0.347987						66
68	SPEECH PATHOLOGY	0.206348						68
69	ELECTROCARDIOLOGY	0.104657						69
70	ELECTROENCEPHALOGRAPHY	0.205335						70
70.01	EMG	0.122470						70.01
70.03	ANGIOGRAPHY	0.231894						70.03
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.198522						71
72	IMPL. DEV. CHARGED TO PATIENTS	0.534869						72
73	DRUGS CHARGED TO PATIENTS	0.333952						73
74	RENAL DIALYSIS	0.302298						74
76.97	CARDIAC REHABILITATION	0.430299						76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT PSYCHE SERVICES	0.343928						90.01
91	EMERGENCY	0.154010						91
91.01	PCC	0.840621						91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.558512						92
	OTHER REIMBURSABLE COST CENTERS							
200	SUBTOTAL (see instructions)							200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES							201
202	NET CHARGES (line 200 - line 201)							202

(A) Worksheet A line numbers



COMPU-MAX

PALOS COMMUNITY HOSPITAL Provider CCN: 14-0062	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 08:45 Version: 2014.03
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS

WORKSHEET D
PART I

CHECK TITLE V PPS
 APPLICABLE TITLE XVIII, PART A TEFRA
 BOXES: TITLE XIX

		CAPITAL RELATED COST (from Wkst. B, Part II, (col. 26)	SWING BED ADJUSTMENT	REDUCED CAPITAL RELATED COST (col. 1 minus col. 2)	TOTAL PATIENT DAYS	PER DIEM (col. 3 ÷ col. 4)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM CAPITAL COST (col. 5 x col. 6)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	7	
	INPATIENT ROUTINE SERV COST CENTERS								
30	ADULTS & PEDIATRICS (General Routine Care)	6,172,108		6,172,108	75,384	81.88	2,804	229,592	30
31	INTENSIVE CARE UNIT	754,801		754,801	5,772	130.77	114	14,908	31
32	CORONARY CARE UNIT								32
33	BURN INTENSIVE CARE UNIT								33
34	SURGICAL INTENSIVE CARE UNIT								34
35	OTHER SPECIAL CARE (SPECIFY)								35
40	SUBPROVIDER - IPF	411,882		411,882	6,694	61.53	467	28,735	40
41	SUBPROVIDER - IRF								41
42	SUBPROVIDER I								42
43	NURSERY				2,141		199		43
44	SKILLED NURSING FACILITY								44
45	NURSING FACILITY								45
200	TOTAL (lines 30-199)	7,338,791		7,338,791	89,991		3,584	273,235	200

(A) Worksheet A line numbers



COMPU-MAX

PALOS COMMUNITY HOSPITAL Provider CCN: 14-0062	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 08:45 Version: 2014.03
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-0062

WORKSHEET D
PART II

CHECK [] TITLE V [XX] HOSPITAL [] SUB (OTHER) [XX] PPS
 APPLICABLE [] TITLE XVIII, PART A [] IPF [] TEFRA
 BOXES: [XX] TITLE XIX [] IRF

(A)	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 (col. 3 x col. 4)	
		1	2	3	4	5	
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM	3,927,856	190,796,193	0.020587	2,689,555	55,370	50
51	RECOVERY ROOM	124,610	12,172,910	0.010237	200,109	2,049	51
53	ANESTHESIOLOGY	159,357	34,952,943	0.004559	564,797	2,575	53
54	RADIOLOGY-DIAGNOSTIC	2,272,382	77,501,909	0.029320	735,084	21,553	54
54.01	ULTRASOUND	168,144	22,777,947	0.007382	368,882	2,723	54.01
57	CT SCAN	429,392	112,330,070	0.003823	1,722,170	6,584	57
58	MRI	390,501	15,067,359	0.025917	305,910	7,928	58
59	CARDIAC CATHETERIZATION	456,077	33,040,017	0.013804	664,477	9,172	59
60	LABORATORY	1,308,885	198,373,835	0.006598	4,191,534	27,656	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	BLOOD STORING, PROCESSING & TRANS.	61,461	7,894,474	0.007785	291,084	2,266	63
64	INTRAVENOUS THERAPY	65,712	7,631,057	0.008611	33,329	287	64
65	RESPIRATORY THERAPY	265,723	40,747,893	0.006521	1,283,457	8,369	65
66	PHYSICAL THERAPY	420,748	23,594,801	0.017832	150,145	2,677	66
68	SPEECH PATHOLOGY	6,087	1,796,123	0.003389	25,465	86	68
69	ELECTROCARDIOLOGY	503,607	42,231,674	0.011925	660,733	7,879	69
70	ELECTROENCEPHALOGRAPHY	38,120	2,212,298	0.017231	40,674	701	70
70.01	EMG	16,805	2,361,253	0.007117	3,097	22	70.01
70.03	ANGIOGRAPHY	163,827	6,972,610	0.023496	218,358	5,131	70.03
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	567,295	33,846,909	0.016761	1,079,883	18,100	71
72	IMPL. DEV. CHARGED TO PATIENTS	160,414	26,577,066	0.006036	259,505	1,566	72
73	DRUGS CHARGED TO PATIENTS	930,236	57,096,371	0.016292	2,266,607	36,928	73
74	RENAL DIALYSIS	17,880	1,709,320	0.010460	77,825	814	74
76.97	CARDIAC REHABILITATION	38,211	3,341,701	0.011435	16,456	188	76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	OUTPATIENT PSYCHE SERVICES	29,081	5,448,429	0.005338			90.01
91	EMERGENCY	997,686	97,578,817	0.010224	1,389,494	14,206	91
91.01	PCC	322,794	7,033,844	0.045892	189	9	91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)	711,423	17,629,967	0.040353			92
	OTHER REIMBURSABLE COST CENTERS						
200	TOTAL (sum of lines 50-199)	14,554,314	1,082,717,790		19,238,819	234,839	200

(A) Worksheet A line numbers



COMPU-MAX

PALOS COMMUNITY HOSPITAL Provider CCN: 14-0062	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 08:45 Version: 2014.03
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

CHECK TITLE V PPS
 APPLICABLE TITLE XVIII, PART A TEFRA
 BOXES: TITLE XIX

		NURSING SCHOOL	ALLIED HEALTH COST	ALL OTHER MEDICAL EDUCATION COST	SWING-BED ADJUSTMENT AMOUNT (see instructions)	TOTAL COSTS (sum of cols. 1 through 3 minus col 4.)	
(A)	COST CENTER DESCRIPTION	1	2	3	4	5	
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS (General Routine Care)						30
31	INTENSIVE CARE UNIT						31
32	CORONARY CARE UNIT						32
33	BURN INTENSIVE CARE UNIT						33
34	SURGICAL INTENSIVE CARE UNIT						34
35	OTHER SPECIAL CARE (SPECIFY)						35
40	SUBPROVIDER - IPF						40
41	SUBPROVIDER - IRF						41
42	SUBPROVIDER I						42
43	NURSERY						43
44	SKILLED NURSING FACILITY						44
45	NURSING FACILITY						45
200	TOTAL (lines 30-199)						200

(A) Worksheet A line numbers



PALOS COMMUNITY HOSPITAL Provider CCN: 14-0062	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 08:45 Version: 2014.03
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APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS

WORKSHEET D
PART III

CHECK TITLE V PPS
 APPLICABLE TITLE XVIII, PART A TEFRA
 BOXES: TITLE XIX

		TOTAL PATIENT DAYS	PER DIEM (col. 5 ÷ col. 6)	INPATIENT PROGRAM DAYS	INPATIENT PROGRAM PASS THRU COST (col. 7 x col. 8)	
(A)	COST CENTER DESCRIPTION	6	7	8	9	
	INPATIENT ROUTINE SERV COST CENTERS					
30	ADULTS & PEDIATRICS (General Routine Care)	75,384		2,804		30
31	INTENSIVE CARE UNIT	5,772		114		31
32	CORONARY CARE UNIT					32
33	BURN INTENSIVE CARE UNIT					33
34	SURGICAL INTENSIVE CARE UNIT					34
35	OTHER SPECIAL CARE (SPECIFY)					35
40	SUBPROVIDER - IPF	6,694		467		40
41	SUBPROVIDER - IRF					41
42	SUBPROVIDER I					42
43	NURSERY	2,141		199		43
44	SKILLED NURSING FACILITY					44
45	NURSING FACILITY					45
200	TOTAL (lines 30-199)	89,991		3,584		200

(A) Worksheet A line numbers



COMPU-MAX

PALOS COMMUNITY HOSPITAL Provider CCN: 14-0062	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 08:45 Version: 2014.03
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
 OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-0062

WORKSHEET D
 PART IV

CHECK TITLE V HOSPITAL SUB (OTHER) ICF/MR PPS
 APPLICABLE TITLE XVIII, PART A IPF SNF TEFRA
 BOXES: TITLE XIX IRF NF

(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
51	RECOVERY ROOM							51
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
54.01	ULTRASOUND							54.01
57	CT SCAN							57
58	MRI							58
59	CARDIAC CATHETERIZATION							59
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.							63
64	INTRAVENOUS THERAPY							64
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY							69
70	ELECTROENCEPHALOGRAPHY							70
70.01	EMG							70.01
70.03	ANGIOGRAPHY							70.03
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS			126,297		126,297	126,297	73
74	RENAL DIALYSIS							74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT PSYCHE SERVICES							90.01
91	EMERGENCY							91
91.01	PCC							91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (sum of lines 50-199)			126,297		126,297	126,297	200

(A) Worksheet A line numbers



COMPU-MAX

PALOS COMMUNITY HOSPITAL Provider CCN: 14-0062	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 08:45 Version: 2014.03
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-0062

WORKSHEET D
PART IV

CHECK [] TITLE V [XX] HOSPITAL [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [] TITLE XVIII, PART A [] IPF [] SNF [] TEFRA
 BOXES: [XX] TITLE XIX [] IRF [] NF

(A)	COST CENTER DESCRIPTION	TOTAL CHARGES (from Wkst. C, Part I, col. 8)	RATIO OF COST TO CHARGES (col. 5÷ col. 7)	OUTPAT-IENT RATIO OF COST TO CHARGES (col. 6÷ col. 7)	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM PASS-THROUGH COSTS (col. 8 x col. 10)	OUTPAT-IENT PROGRAM CHARGES	OUTPAT-IENT PROGRAM PASS-THROUGH COSTS (col. 9 x col. 12)
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	190,796,193			2,689,555			50
51	RECOVERY ROOM	12,172,910			200,109			51
53	ANESTHESIOLOGY	34,952,943			564,797			53
54	RADIOLOGY-DIAGNOSTIC	77,501,909			735,084			54
54.01	ULTRASOUND	22,777,947			368,882			54.01
57	CT SCAN	112,330,070			1,722,170			57
58	MRI	15,067,359			305,910			58
59	CARDIAC CATHETERIZATION	33,040,017			664,477			59
60	LABORATORY	198,373,835			4,191,534			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.	7,894,474			291,084			63
64	INTRAVENOUS THERAPY	7,631,057			33,329			64
65	RESPIRATORY THERAPY	40,747,893			1,283,457			65
66	PHYSICAL THERAPY	23,594,801			150,145			66
68	SPEECH PATHOLOGY	1,796,123			25,465			68
69	ELECTROCARDIOLOGY	42,231,674			660,733			69
70	ELECTROENCEPHALOGRAPHY	2,212,298			40,674			70
70.01	EMG	2,361,253			3,097			70.01
70.03	ANGIOGRAPHY	6,972,610			218,358			70.03
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	33,846,909			1,079,883			71
72	IMPL. DEV. CHARGED TO PATIENTS	26,577,066			259,505			72
73	DRUGS CHARGED TO PATIENTS	57,096,371	0.002212	0.002212	2,266,607	5,014		73
74	RENAL DIALYSIS	1,709,320			77,825			74
76.97	CARDIAC REHABILITATION	3,341,701			16,456			76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT PSYCHE SERVICES	5,448,429						90.01
91	EMERGENCY	97,578,817			1,389,494			91
91.01	PCC	7,033,844			189			91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)	17,629,967						92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (sum of lines 50-199)	1,082,717,790			19,238,819	5,014		200

(A) Worksheet A line numbers



COMPU-MAX

PALOS COMMUNITY HOSPITAL Provider CCN: 14-0062	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 08:45 Version: 2014.03
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-0062

WORKSHEET D
PART V

CHECK [] TITLE V - O/P [XX] HOSPITAL [] SUB (OTHER) [] SWING BED SNF
 APPLICABLE [] TITLE XVIII, PART B [] IPF [] SNF [] SWING BED NF
 BOXES: [XX] TITLE XIX - O/P [] IRF [] NF [] ICF/MR

(A)	COST CENTER DESCRIPTION	COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PROGRAM CHARGES			PROGRAM COST		
			PPS REIM-BURSED SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	PPS SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)
		1	2	3	4	5	6	7
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	0.178306						50
51	RECOVERY ROOM	0.213955						51
53	ANESTHESIOLOGY	0.033661						53
54	RADIOLOGY-DIAGNOSTIC	0.204029						54
54.01	ULTRASOUND	0.104014						54.01
57	CT SCAN	0.034761						57
58	MRI	0.092997						58
59	CARDIAC CATHETERIZATION	0.166434						59
60	LABORATORY	0.095106						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.	0.401646						63
64	INTRAVENOUS THERAPY	0.305255						64
65	RESPIRATORY THERAPY	0.133686						65
66	PHYSICAL THERAPY	0.347987						66
68	SPEECH PATHOLOGY	0.206348						68
69	ELECTROCARDIOLOGY	0.104657						69
70	ELECTROENCEPHALOGRAPHY	0.205335						70
70.01	EMG	0.122470						70.01
70.03	ANGIOGRAPHY	0.231894						70.03
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.198522						71
72	IMPL. DEV. CHARGED TO PATIENTS	0.534869						72
73	DRUGS CHARGED TO PATIENTS	0.333952						73
74	RENAL DIALYSIS	0.302298						74
76.97	CARDIAC REHABILITATION	0.430299						76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT PSYCHE SERVICES	0.343928						90.01
91	EMERGENCY	0.154010						91
91.01	PCC	0.840621						91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.558512						92
	OTHER REIMBURSABLE COST CENTERS							
200	SUBTOTAL (see instructions)							200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES							201
202	NET CHARGES (line 200 - line 201)							202

(A) Worksheet A line numbers



COMPU-MAX

PALOS COMMUNITY HOSPITAL Provider CCN: 14-0062	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 08:45 Version: 2014.03
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APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

COMPONENT CCN: 14-S062

WORKSHEET D
PART II

CHECK TITLE V HOSPITAL SUB (OTHER)
 APPLICABLE TITLE XVIII, PART A IPF
 BOXES: TITLE XIX IRF

(A)	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 (col. 3 x col. 4)
		1	2	3	4	5
	ANCILLARY SERVICE COST CENTERS					
50	OPERATING ROOM	3,927,856	190,796,193	0.020587		50
51	RECOVERY ROOM	124,610	12,172,910	0.010237		51
53	ANESTHESIOLOGY	159,357	34,952,943	0.004559		53
54	RADIOLOGY-DIAGNOSTIC	2,272,382	77,501,909	0.029320		54
54.01	ULTRASOUND	168,144	22,777,947	0.007382		54.01
57	CT SCAN	429,392	112,330,070	0.003823		57
58	MRI	390,501	15,067,359	0.025917		58
59	CARDIAC CATHETERIZATION	456,077	33,040,017	0.013804		59
60	LABORATORY	1,308,885	198,373,835	0.006598		60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS					62.30
63	BLOOD STORING, PROCESSING & TRANS.	61,461	7,894,474	0.007785		63
64	INTRAVENOUS THERAPY	65,712	7,631,057	0.008611		64
65	RESPIRATORY THERAPY	265,723	40,747,893	0.006521		65
66	PHYSICAL THERAPY	420,748	23,594,801	0.017832		66
68	SPEECH PATHOLOGY	6,087	1,796,123	0.003389		68
69	ELECTROCARDIOLOGY	503,607	42,231,674	0.011925		69
70	ELECTROENCEPHALOGRAPHY	38,120	2,212,298	0.017231		70
70.01	EMG	16,805	2,361,253	0.007117		70.01
70.03	ANGIOGRAPHY	163,827	6,972,610	0.023496		70.03
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	567,295	33,846,909	0.016761		71
72	IMPL. DEV. CHARGED TO PATIENTS	160,414	26,577,066	0.006036		72
73	DRUGS CHARGED TO PATIENTS	930,236	57,096,371	0.016292		73
74	RENAL DIALYSIS	17,880	1,709,320	0.010460		74
76.97	CARDIAC REHABILITATION	38,211	3,341,701	0.011435		76.97
76.98	HYPERBARIC OXYGEN THERAPY					76.98
76.99	LITHOTRIPSY					76.99
	OUTPATIENT SERVICE COST CENTERS					
90.01	OUTPATIENT PSYCHE SERVICES	29,081	5,448,429	0.005338		90.01
91	EMERGENCY	997,686	97,578,817	0.010224		91
91.01	PCC	322,794	7,033,844	0.045892		91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)		17,629,967			92
	OTHER REIMBURSABLE COST CENTERS					
200	TOTAL (sum of lines 50-199)	13,842,891	1,082,717,790			200

(A) Worksheet A line numbers



COMPU-MAX

PALOS COMMUNITY HOSPITAL Provider CCN: 14-0062	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 08:45 Version: 2014.03
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
 OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-S062

WORKSHEET D
 PART IV

CHECK [] TITLE V [] HOSPITAL [] SUB (OTHER) [] ICF/MR
 APPLICABLE [] TITLE XVIII, PART A [XX] IPF [] SNF
 BOXES: [XX] TITLE XIX [] IRF [] NF

(A)	COST CENTER DESCRIPTION	1	2	3	4	5	6	
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM							50
51	RECOVERY ROOM							51
53	ANESTHESIOLOGY							53
54	RADIOLOGY-DIAGNOSTIC							54
54.01	ULTRASOUND							54.01
57	CT SCAN							57
58	MRI							58
59	CARDIAC CATHETERIZATION							59
60	LABORATORY							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.							63
64	INTRAVENOUS THERAPY							64
65	RESPIRATORY THERAPY							65
66	PHYSICAL THERAPY							66
68	SPEECH PATHOLOGY							68
69	ELECTROCARDIOLOGY							69
70	ELECTROENCEPHALOGRAPHY							70
70.01	EMG							70.01
70.03	ANGIOGRAPHY							70.03
71	MEDICAL SUPPLIES CHARGED TO PATIENTS							71
72	IMPL. DEV. CHARGED TO PATIENTS							72
73	DRUGS CHARGED TO PATIENTS			126,297		126,297	126,297	73
74	RENAL DIALYSIS							74
76.97	CARDIAC REHABILITATION							76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT PSYCHE SERVICES							90.01
91	EMERGENCY							91
91.01	PCC							91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)							92
	OTHER REIMBURSABLE COST CENTERS							
200	TOTAL (sum of lines 50-199)			126,297		126,297	126,297	200

(A) Worksheet A line numbers



COMPU-MAX

PALOS COMMUNITY HOSPITAL Provider CCN: 14-0062	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 08:45 Version: 2014.03
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APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE
 OTHER PASS THROUGH COSTS

COMPONENT CCN: 14-S062

WORKSHEET D
 PART IV

CHECK [] TITLE V [] HOSPITAL [] SUB (OTHER) [] ICF/MR
 APPLICABLE [] TITLE XVIII, PART A [XX] IPF [] SNF
 BOXES: [XX] TITLE XIX [] IRF [] NF

(A)	COST CENTER DESCRIPTION	TOTAL CHARGES (from Wkst. C, Part I, col. 8)	RATIO OF COST TO CHARGES (col. 5÷ col. 7)	OUTPAT-IENT RATIO OF COST TO CHARGES (col. 6÷ col. 7)	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM PASS-THROUGH COSTS (col. 8 x col. 10)	OUTPAT-IENT PROGRAM CHARGES	OUTPAT-IENT PROGRAM PASS-THROUGH COSTS (col. 9 x col. 12)	
7		8		9	10	11	12	13	
	ANCILLARY SERVICE COST CENTERS								
50	OPERATING ROOM	190,796,193							50
51	RECOVERY ROOM	12,172,910							51
53	ANESTHESIOLOGY	34,952,943							53
54	RADIOLOGY-DIAGNOSTIC	77,501,909							54
54.01	ULTRASOUND	22,777,947							54.01
57	CT SCAN	112,330,070							57
58	MRI	15,067,359							58
59	CARDIAC CATHETERIZATION	33,040,017							59
60	LABORATORY	198,373,835							60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS								62.30
63	BLOOD STORING, PROCESSING & TRANS.	7,894,474							63
64	INTRAVENOUS THERAPY	7,631,057							64
65	RESPIRATORY THERAPY	40,747,893							65
66	PHYSICAL THERAPY	23,594,801							66
68	SPEECH PATHOLOGY	1,796,123							68
69	ELECTROCARDIOLOGY	42,231,674							69
70	ELECTROENCEPHALOGRAPHY	2,212,298							70
70.01	EMG	2,361,253							70.01
70.03	ANGIOGRAPHY	6,972,610							70.03
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	33,846,909							71
72	IMPL. DEV. CHARGED TO PATIENTS	26,577,066							72
73	DRUGS CHARGED TO PATIENTS	57,096,371	0.002212	0.002212					73
74	RENAL DIALYSIS	1,709,320							74
76.97	CARDIAC REHABILITATION	3,341,701							76.97
76.98	HYPERBARIC OXYGEN THERAPY								76.98
76.99	LITHOTRIPSY								76.99
	OUTPATIENT SERVICE COST CENTERS								
90.01	OUTPATIENT PSYCHE SERVICES	5,448,429							90.01
91	EMERGENCY	97,578,817							91
91.01	PCC	7,033,844							91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)	17,629,967							92
	OTHER REIMBURSABLE COST CENTERS								
200	TOTAL (sum of lines 50-199)	1,082,717,790							200

(A) Worksheet A line numbers



COMPU-MAX

PALOS COMMUNITY HOSPITAL Provider CCN: 14-0062	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 08:45 Version: 2014.03
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APPORTIONMENT OF MEDICAL AND OTHER HEALTH SERVICE COSTS

COMPONENT CCN: 14-S062

WORKSHEET D
PART V

CHECK TITLE V - O/P HOSPITAL SUB (OTHER) SWING BED SNF
 APPLICABLE TITLE XVIII, PART B IPF SNF SWING BED NF
 BOXES: TITLE XIX - O/P IRF NF ICF/MR

(A)	COST CENTER DESCRIPTION	PROGRAM CHARGES				PROGRAM COST		
		COST TO CHARGE RATIO (from Wkst C, Part I, col. 9)	PPS REIM-BURSED SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)	PPS SERVICES (see inst.)	COST REIM-BURSED SUBJECT TO DED. & COINS. (see inst.)	COST REIM-BURSED NOT SUBJECT TO DED. & COINS. (see inst.)
		1	2	3	4	5	6	7
	ANCILLARY SERVICE COST CENTERS							
50	OPERATING ROOM	0.178306						50
51	RECOVERY ROOM	0.213955						51
53	ANESTHESIOLOGY	0.033661						53
54	RADIOLOGY-DIAGNOSTIC	0.204029						54
54.01	ULTRASOUND	0.104014						54.01
57	CT SCAN	0.034761						57
58	MRI	0.092997						58
59	CARDIAC CATHETERIZATION	0.166434						59
60	LABORATORY	0.095106						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS							62.30
63	BLOOD STORING, PROCESSING & TRANS.	0.401646						63
64	INTRAVENOUS THERAPY	0.305255						64
65	RESPIRATORY THERAPY	0.133686						65
66	PHYSICAL THERAPY	0.347987						66
68	SPEECH PATHOLOGY	0.206348						68
69	ELECTROCARDIOLOGY	0.104657						69
70	ELECTROENCEPHALOGRAPHY	0.205335						70
70.01	EMG	0.122470						70.01
70.03	ANGIOGRAPHY	0.231894						70.03
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.198522						71
72	IMPL. DEV. CHARGED TO PATIENTS	0.534869						72
73	DRUGS CHARGED TO PATIENTS	0.333952						73
74	RENAL DIALYSIS	0.302298						74
76.97	CARDIAC REHABILITATION	0.430299						76.97
76.98	HYPERBARIC OXYGEN THERAPY							76.98
76.99	LITHOTRIPSY							76.99
	OUTPATIENT SERVICE COST CENTERS							
90.01	OUTPATIENT PSYCHE SERVICES	0.343928						90.01
91	EMERGENCY	0.154010						91
91.01	PCC	0.840621						91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.558512						92
	OTHER REIMBURSABLE COST CENTERS							
200	SUBTOTAL (see instructions)							200
201	LESS PBP CLINIC LAB. SERVICES PROGRAM ONLY CHARGES							201
202	NET CHARGES (line 200 - line 201)							202

(A) Worksheet A line numbers



COMPU-MAX

PALOS COMMUNITY HOSPITAL Provider CCN: 14-0062	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 08:45 Version: 2014.03
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0062

WORKSHEET D-1
PART I

CHECK TITLE V - I/P HOSPITAL SUB (OTHER) ICF/MR PPS
 APPLICABLE TITLE XVIII, PART A IPF SNF TEFRA
 BOXES: TITLE XIX - I/P IRF NF OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	75,384	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	75,384	2
3	PRIVATE ROOM DAYS (excluding swing-bed private room days). IF YOU HAVE ONLY PRIVATE ROOM DAYS, DO NOT COMPLETE THIS LINE.		3
4	SEMI-PRIVATE ROOM DAYS (excluding swing-bed private room days)	66,695	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	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)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	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)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	42,629	9
10	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)		10
11	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)		11
12	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		12
13	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)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed days)		14
15	TOTAL NURSERY DAYS (Title V or Title XIX only)		15
16	TITLE V OR XIX NURSERY DAYS (Title V or Title XIX only)		16

SWING-BED ADJUSTMENT

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (see instructions)	85,426,327	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 5 x line 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 6 x line 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 7 x line 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 8 x line 20)		25
26	TOTAL SWING-BED COST (see instructions)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	85,426,327	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (excluding swing-bed and observation bed charges)		28
29	PRIVATE ROOM CHARGES (excluding swing-bed charges)		29
30	SEMI-PRIVATE ROOM CHARGES (excluding swing-bed charges)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (line 27 ÷ line 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (line 29 ÷ line 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (line 30 ÷ line 4)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (line 32 minus line 33) (see instructions)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (line 34 x line 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (line 3 x line 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (line 27 - line 36)	85,426,327	37



COMPU-MAX

PALOS COMMUNITY HOSPITAL Provider CCN: 14-0062	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 08:45 Version: 2014.03
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0062

WORKSHEET D-1
PART II

CHECK [] TITLE V - I/P [XX] HOSPITAL [] SUB (OTHER) [XX] PPS
 APPLICABLE [XX] TITLE XVIII, PART A [] IPF [] TEFRA
 BOXES: [] TITLE XIX - I/P [] IRF [] OTHER

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)					1,133.22	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)					48,308,035	39
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (line 14 x line 35)						40
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 39 + line 40)					48,308,035	41
		TOTAL INPATIENT COST	TOTAL INPATIENT DAYS	AVERAGE PER DIEM (col. 1 ÷ col. 2)	PROGRAM DAYS	PROGRAM COST (col. 3 x col. 4)	
		1	2	3	4	5	
42	NURSERY (Titles V and XIX only)						42
	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS						
43	INTENSIVE CARE UNIT	11,068,901	5,772	1,917.69	4,690	8,993,966	43
44	CORONARY CARE UNIT						44
45	BURN INTENSIVE CARE UNIT						45
46	SURGICAL INTENSIVE CARE UNIT						46
47	OTHER SPECIAL CARE (SPECIFY)						47

48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)					56,538,021	48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)					113,840,022	49

PASS-THROUGH COST ADJUSTMENTS

50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)					4,103,774	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)					4,052,471	51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)					8,156,245	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)					105,683,777	53

TARGET AMOUNT AND LIMIT COMPUTATION

54	PROGRAM DISCHARGES						54
55	TARGET AMOUNT PER DISCHARGE						55
56	TARGET AMOUNT (line 54 x line 55)						56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT (line 56 minus line 53)						57
58	BONUS PAYMENT (see instructions)						58
59	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET						59
60	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET						60
61	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 (line 54 x 60), OR 1% OF THE TARGET AMOUNT (line 56), OTHERWISE ENTER ZERO (see instructions)						61
62	RELIEF PAYMENT (see instructions)						62
63	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (see instructions)						63

PROGRAM INPATIENT ROUTINE SWING BED COST

64	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)						64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)						65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (Title XVIII only. For CAH, see instructions)						66
67	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 12 x line 19)						67
68	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 13 x line 20)						68
69	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (line 67 + line 68)						69



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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0062

WORKSHEET D-1
PARTS III & IV

CHECK TITLE V - I/P HOSPITAL SUB (OTHER) ICF/MR PPS
 APPLICABLE TITLE XVIII, PART A IPF SNF TEFRA
 BOXES: TITLE XIX - I/P IRF NF OTHER

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	TOTAL OBSERVATION BED DAYS (see instructions)					8,689	87
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (line 27 ÷ line 2)					1,133.22	88
89	OBSERVATION BED COST (line 87 x line 88) (see instructions)					9,846,549	89
		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	2	3	4	5	
90	CAPITAL-RELATED COST	6,172,108	85,426,327	0.072251	9,846,549	711,423	90
91	NURSING SCHOOL COST						91
92	ALLIED HEALTH COST						92
93	ALL OTHER MEDICAL EDUCATION						93



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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-S062

WORKSHEET D-1
PART I

CHECK [] TITLE V - I/P [] HOSPITAL [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [XX] TITLE XVIII, PART A [XX] IPF [] SNF [] TEFRA
 BOXES: [] TITLE XIX - I/P [] IRF [] NF [] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	6,694	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	6,694	2
3	PRIVATE ROOM DAYS (excluding swing-bed private room days). IF YOU HAVE ONLY PRIVATE ROOM DAYS, DO NOT COMPLETE THIS LINE.		3
4	SEMI-PRIVATE ROOM DAYS (excluding swing-bed private room days)	6,694	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	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)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	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)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	2,336	9
10	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)		10
11	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)		11
12	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		12
13	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)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed days)		14
15	TOTAL NURSERY DAYS (Title V or Title XIX only)		15
16	TITLE V OR XIX NURSERY DAYS (Title V or Title XIX only)		16

SWING-BED ADJUSTMENT

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (see instructions)	8,396,838	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 5 x line 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 6 x line 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 7 x line 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 8 x line 20)		25
26	TOTAL SWING-BED COST (see instructions)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	8,396,838	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (excluding swing-bed and observation bed charges)		28
29	PRIVATE ROOM CHARGES (excluding swing-bed charges)		29
30	SEMI-PRIVATE ROOM CHARGES (excluding swing-bed charges)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (line 27 ÷ line 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (line 29 ÷ line 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (line 30 ÷ line 4)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (line 32 minus line 33) (see instructions)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (line 34 x line 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (line 3 x line 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (line 27 - line 36)	8,396,838	37



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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-S062

WORKSHEET D-1
PART II

CHECK [] TITLE V - I/P [] HOSPITAL [] SUB (OTHER) [XX] PPS
 APPLICABLE [XX] TITLE XVIII, PART A [XX] IPF [] TEFRA
 BOXES: [] TITLE XIX - I/P [] IRF [] OTHER

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

1

38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)	1,254.38	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)	2,930,232	39
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (line 14 x line 35)		40
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 39 + line 40)	2,930,232	41
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)	455,452	48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)	3,385,684	49

PASS-THROUGH COST ADJUSTMENTS

50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)	143,734	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)	31,852	51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)	175,586	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)	3,210,098	53

TARGET AMOUNT AND LIMIT COMPUTATION

54	PROGRAM DISCHARGES		54
55	TARGET AMOUNT PER DISCHARGE		55
56	TARGET AMOUNT (line 54 x line 55)		56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT (line 56 minus line 53)		57
58	BONUS PAYMENT (see instructions)		58
59	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET		59
60	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET		60
61	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 (line 54 x 60), OR 1% OF THE TARGET AMOUNT (line 56), OTHERWISE ENTER ZERO (see instructions)		61
62	RELIEF PAYMENT (see instructions)		62
63	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (see instructions)		63

PROGRAM INPATIENT ROUTINE SWING BED COST

64	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)		64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)		65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (Title XVIII only. For CAH, see instructions)		66
67	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 12 x line 19)		67
68	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 13 x line 20)		68
69	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (line 67 + line 68)		69



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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0062

WORKSHEET D-1
PART I

CHECK [] TITLE V - I/P [XX] HOSPITAL [] SUB (OTHER) [] ICF/MR [XX] PPS
 APPLICABLE [] TITLE XVIII, PART A [] IPF [] SNF [] TEFRA
 BOXES: [XX] TITLE XIX - I/P [] IRF [] NF [] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	75,384	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	75,384	2
3	PRIVATE ROOM DAYS (excluding swing-bed private room days). IF YOU HAVE ONLY PRIVATE ROOM DAYS, DO NOT COMPLETE THIS LINE.		3
4	SEMI-PRIVATE ROOM DAYS (excluding swing-bed private room days)	66,695	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	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)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	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)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	2,804	9
10	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)		10
11	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)		11
12	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		12
13	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)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed days)		14
15	TOTAL NURSERY DAYS (Title V or Title XIX only)	2,141	15
16	TITLE V OR XIX NURSERY DAYS (Title V or Title XIX only)	199	16

SWING-BED ADJUSTMENT

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (see instructions)	85,426,327	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 5 x line 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 6 x line 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 7 x line 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 8 x line 20)		25
26	TOTAL SWING-BED COST (see instructions)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	85,426,327	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (excluding swing-bed and observation bed charges)		28
29	PRIVATE ROOM CHARGES (excluding swing-bed charges)		29
30	SEMI-PRIVATE ROOM CHARGES (excluding swing-bed charges)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (line 27 ÷ line 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (line 29 ÷ line 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (line 30 ÷ line 4)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (line 32 minus line 33) (see instructions)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (line 34 x line 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (line 3 x line 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (line 27 - line 36)	85,426,327	37



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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0062

WORKSHEET D-1
PART II

CHECK [] TITLE V - I/P [XX] HOSPITAL [] SUB (OTHER) [XX] PPS
 APPLICABLE [] TITLE XVIII, PART A [] IPF [] TEFRA
 BOXES: [XX] TITLE XIX - I/P [] IRF [] OTHER

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

							1	
	TOTAL INPATIENT COST	TOTAL INPATIENT DAYS	AVERAGE PER DIEM (col. 1 ÷ col. 2)	PROGRAM DAYS	PROGRAM COST (col. 3 x col. 4)			
	1	2	3	4	5			
38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)						1,133.22	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)						3,177,549	39
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (line 14 x line 35)							40
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 39 + line 40)						3,177,549	41
42	NURSERY (Titles V and XIX only)							42
	INTENSIVE CARE TYPE INPATIENT HOSPITAL UNITS							
		2,141		199				
43	INTENSIVE CARE UNIT							43
44	CORONARY CARE UNIT							44
45	BURN INTENSIVE CARE UNIT							45
46	SURGICAL INTENSIVE CARE UNIT							46
47	OTHER SPECIAL CARE (SPECIFY)							47

							1	
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)						3,169,601	48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)						6,565,767	49

PASS-THROUGH COST ADJUSTMENTS

50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)						244,500	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)						239,853	51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)						484,353	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)						6,081,414	53

TARGET AMOUNT AND LIMIT COMPUTATION

54	PROGRAM DISCHARGES							54
55	TARGET AMOUNT PER DISCHARGE							55
56	TARGET AMOUNT (line 54 x line 55)							56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT (line 56 minus line 53)							57
58	BONUS PAYMENT (see instructions)							58
59	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET							59
60	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET							60
61	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 (line 54 x 60), OR 1% OF THE TARGET AMOUNT (line 56), OTHERWISE ENTER ZERO (see instructions)							61
62	RELIEF PAYMENT (see instructions)							62
63	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (see instructions)							63

PROGRAM INPATIENT ROUTINE SWING BED COST

64	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)							64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)							65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (Title XVIII only. For CAH, see instructions)							66
67	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 12 x line 19)							67
68	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 13 x line 20)							68
69	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (line 67 + line 68)							69



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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-0062

WORKSHEET D-1
PARTS III & IV

CHECK TITLE V - I/P HOSPITAL SUB (OTHER) ICF/MR PPS
 APPLICABLE TITLE XVIII, PART A IPF SNF TEFRA
 BOXES: TITLE XIX - I/P IRF NF OTHER

PART IV - COMPUTATION OF OBSERVATION BED PASS-THROUGH COST

87	TOTAL OBSERVATION BED DAYS (see instructions)	8,689	87				
88	ADJUSTED GENERAL INPATIENT ROUTINE COST PER DIEM (line 27 ÷ line 2)		88				
89	OBSERVATION BED COST (line 87 x line 88) (see instructions)		89				
		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	2	3	4	5	
90	CAPITAL-RELATED COST						90
91	NURSING SCHOOL COST						91
92	ALLIED HEALTH COST						92
93	ALL OTHER MEDICAL EDUCATION						93



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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-S062

WORKSHEET D-1
PART I

CHECK [] TITLE V - I/P [] HOSPITAL [] SUB (OTHER) [] ICF/MR [] PPS
 APPLICABLE [] TITLE XVIII, PART A [XX] IPF [] SNF [] TEFRA
 BOXES: [XX] TITLE XIX - I/P [] IRF [] NF [XX] OTHER

PART I - ALL PROVIDER COMPONENTS

INPATIENT DAYS

1	INPATIENT DAYS (including private room days and swing-bed days, excluding newborn)	6,694	1
2	INPATIENT DAYS (including private room days, excluding swing-bed and newborn days)	6,694	2
3	PRIVATE ROOM DAYS (excluding swing-bed private room days). IF YOU HAVE ONLY PRIVATE ROOM DAYS, DO NOT COMPLETE THIS LINE.		3
4	SEMI-PRIVATE ROOM DAYS (excluding swing-bed private room days)	6,694	4
5	TOTAL SWING-BED SNF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		5
6	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)		6
7	TOTAL SWING-BED NF-TYPE INPATIENT DAYS (including private room days) THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		7
8	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)		8
9	INPATIENT DAYS INCLUDING PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed and newborn days)	467	9
10	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)		10
11	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)		11
12	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		12
13	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)		13
14	MEDICALLY NECESSARY PRIVATE ROOM DAYS APPLICABLE TO THE PROGRAM (excluding swing-bed days)		14
15	TOTAL NURSERY DAYS (Title V or Title XIX only)		15
16	TITLE V OR XIX NURSERY DAYS (Title V or Title XIX only)		16

SWING-BED ADJUSTMENT

17	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		17
18	MEDICARE RATE FOR SWING-BED SNF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		18
19	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD		19
20	MEDICAID RATE FOR SWING-BED NF SERVICES APPLICABLE TO SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD		20
21	TOTAL GENERAL INPATIENT ROUTINE SERVICE COST (see instructions)	8,396,838	21
22	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 5 x line 17)		22
23	SWING-BED COST APPLICABLE TO SNF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 6 x line 18)		23
24	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 7 x line 19)		24
25	SWING-BED COST APPLICABLE TO NF-TYPE SERVICES AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 8 x line 20)		25
26	TOTAL SWING-BED COST (see instructions)		26
27	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST	8,396,838	27

PRIVATE ROOM DIFFERENTIAL ADJUSTMENT

28	GENERAL INPATIENT ROUTINE SERVICE CHARGES (excluding swing-bed and observation bed charges)		28
29	PRIVATE ROOM CHARGES (excluding swing-bed charges)		29
30	SEMI-PRIVATE ROOM CHARGES (excluding swing-bed charges)		30
31	GENERAL INPATIENT ROUTINE SERVICE COST/CHARGE RATIO (line 27 ÷ line 28)		31
32	AVERAGE PRIVATE ROOM PER DIEM CHARGE (line 29 ÷ line 3)		32
33	AVERAGE SEMI-PRIVATE ROOM PER DIEM CHARGE (line 30 ÷ line 4)		33
34	AVERAGE PER DIEM PRIVATE ROOM CHARGE DIFFERENTIAL (line 32 minus line 33) (see instructions)		34
35	AVERAGE PER DIEM PRIVATE ROOM COST DIFFERENTIAL (line 34 x line 31)		35
36	PRIVATE ROOM COST DIFFERENTIAL ADJUSTMENT (line 3 x line 35)		36
37	GENERAL INPATIENT ROUTINE SERVICE COST NET OF SWING-BED COST AND PRIVATE ROOM COST DIFFERENTIAL (line 27 - line 36)	8,396,838	37



COMPU-MAX

PALOS COMMUNITY HOSPITAL Provider CCN: 14-0062	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 08:45 Version: 2014.03
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COMPUTATION OF INPATIENT OPERATING COST

COMPONENT CCN: 14-S062

WORKSHEET D-1
PART II

CHECK TITLE V - I/P HOSPITAL SUB (OTHER) PPS
 APPLICABLE TITLE XVIII, PART A IPF TEFRA
 BOXES: TITLE XIX - I/P IRF OTHER

PART II - HOSPITALS AND SUBPROVIDERS ONLY

PROGRAM INPATIENT OPERATING COST BEFORE PASS-THROUGH COST ADJUSTMENTS

1

38	ADJUSTED GENERAL INPATIENT ROUTINE SERVICE COST PER DIEM (see instructions)	1,254.38	38
39	PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 9 x line 38)	585,795	39
40	MEDICALLY NECESSARY PRIVATE ROOM COST APPLICABLE TO THE PROGRAM (line 14 x line 35)		40
41	TOTAL PROGRAM GENERAL INPATIENT ROUTINE SERVICE COST (line 39 + line 40)	585,795	41
48	PROGRAM INPATIENT ANCILLARY SERVICE COST (Worksheet D-3, column 3, line 200)		48
49	TOTAL PROGRAM INPATIENT COSTS (sum of lines 41 through 48)(see instructions)	585,795	49

PASS-THROUGH COST ADJUSTMENTS

50	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ROUTINE SERVICES (from Worksheet D, sum of Parts I and III)	28,735	50
51	PASS THROUGH COSTS APPLICABLE TO PROGRAM INPATIENT ANCILLARY SERVICES (from Worksheet D, sum of Parts II and IV)		51
52	TOTAL PROGRAM EXCLUDABLE COST (sum of lines 50 and 51)	28,735	52
53	TOTAL PROGRAM INPATIENT OPERATING COST EXCLUDING CAPITAL RELATED, NONPHYSICIAN ANESTHETIST AND MEDICAL EDUCATION COSTS (line 49 minus line 52)		53

TARGET AMOUNT AND LIMIT COMPUTATION

54	PROGRAM DISCHARGES		54
55	TARGET AMOUNT PER DISCHARGE		55
56	TARGET AMOUNT (line 54 x line 55)		56
57	DIFFERENCE BETWEEN ADJUSTED INPATIENT OPERATING COST AND TARGET AMOUNT (line 56 minus line 53)		57
58	BONUS PAYMENT (see instructions)		58
59	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM THE COST REPORTING PERIOD ENDING 1996, UPDATED AND COMPOUNDED BY THE MARKET BASKET		59
60	LESSER OF LINE 53 ÷ LINE 54 OR LINE 55 FROM PRIOR YEAR COST REPORT, UPDATED BY THE MARKET BASKET		60
61	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 (line 54 x 60), OR 1% OF THE TARGET AMOUNT (line 56), OTHERWISE ENTER ZERO (see instructions)		61
62	RELIEF PAYMENT (see instructions)		62
63	ALLOWABLE INPATIENT COST PLUS INCENTIVE PAYMENT (see instructions)		63

PROGRAM INPATIENT ROUTINE SWING BED COST

64	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)		64
65	MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (see instructions) (Title XVIII only)		65
66	TOTAL MEDICARE SWING-BED SNF INPATIENT ROUTINE COSTS (Title XVIII only. For CAH, see instructions)		66
67	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS THROUGH DECEMBER 31 OF THE COST REPORTING PERIOD (line 12 x line 19)		67
68	TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS AFTER DECEMBER 31 OF THE COST REPORTING PERIOD (line 13 x line 20)		68
69	TOTAL TITLE V OR XIX SWING-BED NF INPATIENT ROUTINE COSTS (line 67 + line 68)		69



COMPU-MAX

PALOS COMMUNITY HOSPITAL Provider CCN: 14-0062	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 08:45 Version: 2014.03
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-0062

WORKSHEET D-3

CHECK [] TITLE V - O/P [XX] HOSPITAL [] SUB (OTHER) [] SWING BED SNF [XX] PPS
 APPLICABLE [XX] TITLE XVIII, PART B [] IPF [] SNF [] SWING BED NF [] TEFRA
 BOXES: [] TITLE XIX - O/P [] IRF [] NF [] ICF/MR [] OTHER

(A)	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM COSTS (col. 1 x col. 2)	
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS		69,387,089		30
31	INTENSIVE CARE UNIT		11,263,421		31
40	SUBPROVIDER - IPF				40
43	NURSERY				43
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.178306	48,808,134	8,702,783	50
51	RECOVERY ROOM	0.213955	3,793,045	811,541	51
53	ANESTHESIOLOGY	0.036002	10,031,384	361,150	53
54	RADIOLOGY-DIAGNOSTIC	0.204029	13,274,261	2,708,334	54
54.01	ULTRASOUND	0.104014	5,716,454	594,591	54.01
57	CT SCAN	0.034761	23,373,317	812,480	57
58	MRI	0.092997	3,696,049	343,721	58
59	CARDIAC CATHETERIZATION	0.166881	11,463,851	1,913,099	59
60	LABORATORY	0.095106	64,340,552	6,119,173	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63	BLOOD STORING, PROCESSING & TRANS.	0.401646	3,739,415	1,501,921	63
64	INTRAVENOUS THERAPY	0.305255	600,906	183,430	64
65	RESPIRATORY THERAPY	0.134236	26,764,541	3,592,765	65
66	PHYSICAL THERAPY	0.350817	6,219,769	2,182,001	66
68	SPEECH PATHOLOGY	0.206348	971,842	200,538	68
69	ELECTROCARDIOLOGY	0.104657	13,684,950	1,432,226	69
70	ELECTROENCEPHALOGRAPHY	0.205335	413,580	84,922	70
70.01	EMG	0.122470	131,053	16,050	70.01
70.03	ANGIOGRAPHY	0.231894	3,695,380	856,936	70.03
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.198522	14,495,452	2,877,666	71
72	IMPL. DEV. CHARGED TO PATIENTS	0.534869	11,888,931	6,359,021	72
73	DRUGS CHARGED TO PATIENTS	0.333952	29,422,104	9,825,570	73
74	RENAL DIALYSIS	0.302298	1,194,316	361,039	74
76.97	CARDIAC REHABILITATION	0.430299	456,275	196,335	76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90.01	OUTPATIENT PSYCHE SERVICES	0.343928	6,806	2,341	90.01
91	EMERGENCY	0.154010	20,500,432	3,157,272	91
91.01	PCC	0.840621	47,443	39,882	91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.558512	2,329,823	1,301,234	92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)		321,060,065	56,538,021	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		321,060,065		202

(A) Worksheet A line numbers



COMPU-MAX

PALOS COMMUNITY HOSPITAL Provider CCN: 14-0062	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 08:45 Version: 2014.03
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-S062

WORKSHEET D-3

CHECK [] TITLE V - O/P [] HOSPITAL [] SUB (OTHER) [] SWING BED SNF [XX] PPS
 APPLICABLE [XX] TITLE XVIII, PART B [XX] IPF [] SNF [] SWING BED NF [] TEFRA
 BOXES: [] TITLE XIX - O/P [] IRF [] NF [] ICF/MR [] OTHER

(A)	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM COSTS (col. 1 x col. 2)	
		1	2	3	
INPATIENT ROUTINE SERVICE COST CENTERS					
30	ADULTS & PEDIATRICS				30
31	INTENSIVE CARE UNIT				31
40	SUBPROVIDER - IPF		5,100,728		40
43	NURSERY				43
ANCILLARY SERVICE COST CENTERS					
50	OPERATING ROOM	0.178306	37,060	6,608	50
51	RECOVERY ROOM	0.213955	610	131	51
53	ANESTHESIOLOGY	0.036002	5,415	195	53
54	RADIOLOGY-DIAGNOSTIC	0.204029	70,616	14,408	54
54.01	ULTRASOUND	0.104014	35,635	3,707	54.01
57	CT SCAN	0.034761	238,499	8,290	57
58	MRI	0.092997	51,718	4,810	58
59	CARDIAC CATHETERIZATION	0.166881			59
60	LABORATORY	0.095106	1,149,636	109,337	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63	BLOOD STORING, PROCESSING & TRANS.	0.401646			63
64	INTRAVENOUS THERAPY	0.305255	3,893	1,188	64
65	RESPIRATORY THERAPY	0.134236	123,109	16,526	65
66	PHYSICAL THERAPY	0.350817	80,870	28,371	66
68	SPEECH PATHOLOGY	0.206348	8,882	1,833	68
69	ELECTROCARDIOLOGY	0.104657	75,335	7,884	69
70	ELECTROENCEPHALOGRAPHY	0.205335	22,983	4,719	70
70.01	EMG	0.122470	8,666	1,061	70.01
70.03	ANGIOGRAPHY	0.231894			70.03
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.198522	68,371	13,573	71
72	IMPL. DEV. CHARGED TO PATIENTS	0.534869			72
73	DRUGS CHARGED TO PATIENTS	0.333952	356,920	119,194	73
74	RENAL DIALYSIS	0.302298	7,075	2,139	74
76.97	CARDIAC REHABILITATION	0.430299			76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS					
90.01	OUTPATIENT PSYCHE SERVICES	0.343928			90.01
91	EMERGENCY	0.154010	722,450	111,265	91
91.01	PCC	0.840621	253	213	91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.558512			92
OTHER REIMBURSABLE COST CENTERS					
200	TOTAL (sum of lines 50-94, and 96-98)		3,067,996	455,452	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		3,067,996		202

(A) Worksheet A line numbers



COMPU-MAX

PALOS COMMUNITY HOSPITAL Provider CCN: 14-0062	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 08:45 Version: 2014.03
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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-0062

WORKSHEET D-3

CHECK [] TITLE V - O/P [XX] HOSPITAL [] SUB (OTHER) [] SWING BED SNF [XX] PPS
 APPLICABLE [] TITLE XVIII, PART B [] IPF [] SNF [] SWING BED NF [] TEFRA
 BOXES: [XX] TITLE XIX - O/P [] IRF [] NF [] ICF/MR [] OTHER

(A)	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM COSTS (col. 1 x col. 2)	
		1	2	3	
INPATIENT ROUTINE SERVICE COST CENTERS					
30	ADULTS & PEDIATRICS		4,984,279		30
31	INTENSIVE CARE UNIT		1,056,184		31
40	SUBPROVIDER - IPF				40
ANCILLARY SERVICE COST CENTERS					
50	OPERATING ROOM	0.178306	2,689,555	479,564	50
51	RECOVERY ROOM	0.213955	200,109	42,814	51
53	ANESTHESIOLOGY	0.036002	564,797	20,334	53
54	RADIOLOGY-DIAGNOSTIC	0.204029	735,084	149,978	54
54.01	ULTRASOUND	0.104014	368,882	38,369	54.01
57	CT SCAN	0.034761	1,722,170	59,864	57
58	MRI	0.092997	305,910	28,449	58
59	CARDIAC CATHETERIZATION	0.166881	664,477	110,889	59
60	LABORATORY	0.095106	4,191,534	398,640	60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63	BLOOD STORING, PROCESSING & TRANS.	0.401646	291,084	116,913	63
64	INTRAVENOUS THERAPY	0.305255	33,329	10,174	64
65	RESPIRATORY THERAPY	0.134236	1,283,457	172,286	65
66	PHYSICAL THERAPY	0.350817	150,145	52,673	66
68	SPEECH PATHOLOGY	0.206348	25,465	5,255	68
69	ELECTROCARDIOLOGY	0.104657	660,733	69,150	69
70	ELECTROENCEPHALOGRAPHY	0.205335	40,674	8,352	70
70.01	EMG	0.122470	3,097	379	70.01
70.03	ANGIOGRAPHY	0.231894	218,358	50,636	70.03
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.198522	1,079,883	214,381	71
72	IMPL. DEV. CHARGED TO PATIENTS	0.534869	259,505	138,801	72
73	DRUGS CHARGED TO PATIENTS	0.333952	2,266,607	756,938	73
74	RENAL DIALYSIS	0.302298	77,825	23,526	74
76.97	CARDIAC REHABILITATION	0.430299	16,456	7,081	76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
OUTPATIENT SERVICE COST CENTERS					
90.01	OUTPATIENT PSYCHE SERVICES	0.343928			90.01
91	EMERGENCY	0.154010	1,389,494	213,996	91
91.01	PCC	0.840621	189	159	91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.558512			92
OTHER REIMBURSABLE COST CENTERS					
200	TOTAL (sum of lines 50-94, and 96-98)		19,238,819	3,169,601	200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)		19,238,819		202

(A) Worksheet A line numbers



COMPU-MAX

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INPATIENT ANCILLARY SERVICE COST APPORTIONMENT

COMPONENT CCN: 14-S062

WORKSHEET D-3

CHECK TITLE V - O/P HOSPITAL SUB (OTHER) SWING BED SNF PPS
 APPLICABLE TITLE XVIII, PART B IPF SNF SWING BED NF TEFRA
 BOXES: TITLE XIX - O/P IRF NF ICF/MR OTHER

(A)	COST CENTER DESCRIPTION	RATIO OF COST TO CHARGES	INPATIENT PROGRAM CHARGES	INPATIENT PROGRAM COSTS (col. 1 x col. 2)	
		1	2	3	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30	ADULTS & PEDIATRICS				30
31	INTENSIVE CARE UNIT				31
40	SUBPROVIDER - IPF				40
43	NURSERY				43
	ANCILLARY SERVICE COST CENTERS				
50	OPERATING ROOM	0.178306			50
51	RECOVERY ROOM	0.213955			51
53	ANESTHESIOLOGY	0.033661			53
54	RADIOLOGY-DIAGNOSTIC	0.204029			54
54.01	ULTRASOUND	0.104014			54.01
57	CT SCAN	0.034761			57
58	MRI	0.092997			58
59	CARDIAC CATHETERIZATION	0.166434			59
60	LABORATORY	0.095106			60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS				62.30
63	BLOOD STORING, PROCESSING & TRANS.	0.401646			63
64	INTRAVENOUS THERAPY	0.305255			64
65	RESPIRATORY THERAPY	0.133686			65
66	PHYSICAL THERAPY	0.347987			66
68	SPEECH PATHOLOGY	0.206348			68
69	ELECTROCARDIOLOGY	0.104657			69
70	ELECTROENCEPHALOGRAPHY	0.205335			70
70.01	EMG	0.122470			70.01
70.03	ANGIOGRAPHY	0.231894			70.03
71	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.198522			71
72	IMPL. DEV. CHARGED TO PATIENTS	0.534869			72
73	DRUGS CHARGED TO PATIENTS	0.333952			73
74	RENAL DIALYSIS	0.302298			74
76.97	CARDIAC REHABILITATION	0.430299			76.97
76.98	HYPERBARIC OXYGEN THERAPY				76.98
76.99	LITHOTRIPSY				76.99
	OUTPATIENT SERVICE COST CENTERS				
90.01	OUTPATIENT PSYCHE SERVICES	0.343928			90.01
91	EMERGENCY	0.154010			91
91.01	PCC	0.840621			91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)	0.558512			92
	OTHER REIMBURSABLE COST CENTERS				
200	TOTAL (sum of lines 50-94, and 96-98)				200
201	LESS PBP CLINIC LABORATORY SERVICES-PROGRAM ONLY CHARGES (line 61)				201
202	NET CHARGES (line 200 minus line 201)				202

(A) Worksheet A line numbers



PALOS COMMUNITY HOSPITAL Provider CCN: 14-0062	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 08:45 Version: 2014.03
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CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART A

CHECK
APPLICABLE BOX:

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
1	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS				1
1.01	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS FOR DISCHARGES OCCURRING PRIOR TO OCTOBER 1, 2013 (see instructions)	57,555,854			1.01
1.02	DRG AMOUNTS OTHER THAN OUTLIER PAYMENTS FOR DISCHARGES OCCURRING ON OR AFTER OCTOBER 1, 2013 (see instructions)	19,185,284			1.02
1.03	DRG FOR FEDERAL SPECIFIC OPERATING PAYMENT FOR MODEL 4 BPCI (see instructions)				1.03
2	OUTLIER PAYMENTS FOR DISCHARGES (see instructions)	2,202,448			2
2.01	OUTLIER RECONCILIATION AMOUNT				2.01
2.02	OUTLIER PAYMENT FOR MODEL 4 BPCI (see instructions)				
3	MANAGED CARE SIMULATED PAYMENTS				3
4	BED DAYS AVAILABLE DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (see instructions)	300.19			4
	INDIRECT MEDICAL EDUCATION ADJUSTMENT CALCULATION FOR HOSPITALS				
5	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS FOR THE MOST RECENT COST REPORTING PERIOD ENDING ON OR BEFORE 12/31/1996 (see instructions)				5
6	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)				6
7	MMA SECTION 422 REDUCTION AMOUNT TO THE IME CAP AS SPECIFIED UNDER 42 CFR §412.105(f)(1)(iv)(B)(1)				7
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				7.01
8	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				8
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				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)				8.02
9	SUM OF LINES 5 PLUS 6 MINUS LINES (7 AND 7.01) PLUS/MINUS LINES (8, 8.01 AND 8.02) (see instructions)				9
10	FTE COUNT FOR ALLOPATHIC AND OSTEOPATHIC PROGRAMS IN THE CURRENT YEAR FROM YOUR RECORDS				10
11	FTE COUNT FOR RESIDENTS IN DENTAL AND AND PODIATRIC PROGRAMS				11
12	CURRENT YEAR ALLOWABLE FTE (see instructions)				12
13	TOTAL ALLOWABLE FTE COUNT FOR THE PRIOR YEAR				13
14	TOTAL ALLOWABLE FTE COUNT FOR THE PENULTIMATE YEAR IF THAT YEAR ENDED ON OR AFTER SEPTEMBER 30, 1997, OTHERWISE ENTER ZERO				14
15	SUM OF LINES 12 THROUGH 14 DIVIDED BY 3				15
16	ADJUSTMENT FOR RESIDENTS IN INITIAL YEARS OF THE PROGRAM				16
17	ADJUSTMENT FOR RESIDENTS DISPLACED BY PROGRAM OR HOSPITAL CLOSURE				17
18	ADJUSTED ROLLING AVERAGE FTE COUNT				18
19	CURRENT YEAR RESIDENT TO BED RATIO (line 18 divided by line 4)				19
20	PRIOR YEAR RESIDENT TO BED RATIO (see instructions)				20
21	ENTER THE LESSER OF LINES 19 OR 20 (see instructions)				21
22	IME PAYMENT ADJUSTMENT (see instructions)				22
	INDIRECT MEDICAL EDUCATION ADJUSTMENT FOR THE ADD-ON				
23	NUMBER OF ADDITIONAL ALLOPATHIC AND OSTEOPATHIC IME FTE RESIDENT CAP SLOTS UNDER 42 SEC. 412.105(f)(1)(iv)(C)				23
24	IME FTE RESIDENT COUNT OVER CAP (see instructions)				24
25	IF THE AMOUNT ON LINE 24 IS GREATER THAN -0-, THEN ENTER THE LOWER OF LINE 23 OR LINE 24 (see instructions)				25
26	RESIDENT TO BED RATIO (divide line 25 by line 4)				26
27	IME PAYMENTS ADJUSTMENT (see instructions)				27
28	IME ADJUSTMENT (see instructions)				28
29	TOTAL IME PAYMENT (sum of lines 22 and 28)				29
	DISPROPORTIONATE SHARE ADJUSTMENT				
30	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (see instructions)				30
31	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL (see instructions)				31
32	SUM OF LINES 30 AND 31				32
33	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (see instructions)				33
34	DISPROPORTIONATE SHARE ADJUSTMENT (see instructions)				34
		PRIOR TO OCTOBER 1	ON OR AFTER OCTOBER 1		
	UNCOMPENSATED CARE ADJUSTMENT				
35	TOTAL UNCOMPENSATED CARE AMOUNT (see instructions)				35
35.01	FACTOR 3 (see instructions)				35.01
35.02	HOSPITAL UNCOMPENSATED CARE PAYMENT (if line 34 is zero, enter zero on this line) (see instructions)				35.02
35.03	PRO RATA SHARE OF THE HOSPITAL UNCOMPENSATED CARE PAYMENT AMOUNT (see instructions)				35.03
36	TOTAL UNCOMPENSATED CARE (sum of columns 1 and 2 on line 35.03)				36
	ADDITIONAL PAYMENT FOR HIGH PERCENTAGE OF ESRD BENEFICIARY DISCHARGES				
40	TOTAL MEDICARE DISCHARGES ON WORKSHEET S-3, PART I EXCLUDING DISCHARGES FOR MS-DRGs 652, 682, 683, 684 AND 685 (see instructions)				40



COMPU-MAX

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CALCULATION OF REIMBURSEMENT SETTLEMENT

WORKSHEET E
PART A

CHECK

APPLICABLE BOX:

PART A - INPATIENT HOSPITAL SERVICES UNDER PPS

		1	1.01	1.02	
41	TOTAL ESRD MEDICARE DISCHARGES EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (see instructions)				41
42	DIVIDE LINE 41 BY LINE 40 (if less than 10%, you do not qualify for adjustment)				42
43	TOTAL MEDICARE ESRD INPATIENT DAYS EXCLUDING MS-DRGs 652, 682, 683, 684 AND 685 (see instructions)				43
44	RATIO OF AVERAGE LENGTH OF STAY TO ONE WEEK (line 43 divided by line 41 divided by 7 days)				44
45	AVERAGE WEEKLY COST FOR DIALYSIS TREATMENTS (see instructions)				45
46	TOTAL ADDITIONAL PAYMENT (line 45 times line 44 times line 41)				46
47	SUBTOTAL (see instructions)	78,943,586			47
48	HOSPITAL SPECIFIC PAYMENTS (to be completed by SCH and MDH, small rural hospitals only (see instructions)				48
49	TOTAL PAYMENT FOR INPATIENT OPERATING COSTS SCH AND MDH ONLY (see instructions)	78,943,586			49
50	PAYMENT FOR INPATIENT PROGRAM CAPITAL (from Wkst L, Parts I, II, as applicable)	6,205,748			50
51	EXCEPTION PAYMENT FOR INPATIENT PROGRAM CAPITAL (Wkst L, Part III) (see instructions)				51
52	DIRECT GRADUATE MEDICAL EDUCATION PAYMENT (from Wkst E-4, line 49) (see instructions)				52
53	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT				53
54	SPECIAL ADD-ON PAYMENTS FOR NEW TECHNOLOGIES	8,172			54
55	NET ORGAN ACQUISITION COST (Wkst D-4, Part III, col. 1, line 69)				55
56	COST OF TEACHING PHYSICIANS (Wkst D-5, Part II, col. 3, line 20)				56
57	ROUTINE SERVICE OTHER PASS THROUGH COSTS				57
58	ANCILLARY SERVICE OTHER PASS THROUGH COSTS (Wkst D, Part IV, col. 11, line 200)	65,082			58
59	TOTAL (sum of amounts on lines 49 through 58)	85,222,588			59
60	PRIMARY PAYER PAYMENTS	26,933			60
61	TOTAL AMOUNT PAYABLE FOR PROGRAM BENEFICIARIES (line 59 minus line 60)	85,195,655			61
62	DEDUCTIBLES BILLED TO PROGRAM BENEFICIARIES	7,551,204			62
63	COINSURANCE BILLED TO PROGRAM BENEFICIARIES	226,027			63
64	ALLOWABLE BAD DEBTS (see instructions)	734,779			64
65	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	477,606			65
66	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	463,536			66
67	SUBTOTAL (line 61 plus line 65 minus lines 62 and 63)	77,896,030			67
68	CREDITS RECEIVED FROM MANUFACTURERS FOR REPLACED DEVICES APPLICABLE TO MS-DRG (see instructions)				68
69	OUTLIER PAYMENTS RECONCILIATION				69
70	OTHER ADJUSTMENTS (SPECIFY) (see instructions)				70
70.93	HVBP PAYMENT ADJUSTMENT (see instructions)	-130,994			70.93
70.94	HOSPITAL READMISSIONS REDUCTION ADJUSTMENT (see instructions)	-756,051			70.94
71	AMOUNT DUE PROVIDER (see instructions)	77,008,985			71
71.01	SEQUESTRATION ADJUSTMENT (see instructions)	1,162,836			71.01
72	INTERIM PAYMENTS	75,744,500			72
73	TENTATIVE SETTLEMENT (for contractor use only)				73
74	BALANCE DUE PROVIDER/PROGRAM (line 71 minus lines 71.01, 72 and 73)	101,649			74
75	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-2, SECTION 115.2				75

TO BE COMPLETED BY CONTRACTOR

90	OPERATING OUTLIER AMOUNT FROM WORKSHEET E, PART A, LINE 2				90
91	CAPITAL OUTLIER FROM WORKSHEET L, PART I, LINE 2				91
92	OPERATING OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (see instructions)				92
93	CAPITAL OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (see instructions)				93
94	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY (see instructions)				94
95	TIME VALUE OF MONEY FOR OPERATING EXPENSES (see instructions)				95
96	TIME VALUE OF MONEY FOR CAPITAL RELATED EXPENSES (see instructions)				96



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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-0062

**WORKSHEET E
PART B**

CHECK APPLICABLE BOX: HOSPITAL IPF IRF SUB (OTHER) SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	MEDICAL AND OTHER SERVICES (see instructions)	92,927			1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPTS (see instructions)	27,758,568			2
3	PPS PAYMENTS	23,058,573			3
4	OUTLIER PAYMENT (see instructions)	53,685			4
5	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO (see instructions)				5
6	LINE 2 TIMES LINE 5				6
7	SUM OF LINE 3 PLUS LINE 4 DIVIDED BY LINE 6				7
8	TRANSITIONAL CORRIDOR PAYMENT (see instructions)				8
9	ANCILLARY SERVICE OTHER PASS THROUGH COSTS FROM WKST D, PART IV, COL. 13, LINE 200	10,216			9
10	ORGAN ACQUISITION				10
11	TOTAL COST (sum of lines 1 and 10) (see instructions)	92,927			11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	ANCILLARY SERVICE CHARGES	284,774			12
13	ORGAN ACQUISITION CHARGES (from Wkst D-4, Part III, line 69, col. 4)				13
14	TOTAL REASONABLE CHARGES (sum of lines 12 and 13)	284,774			14
	CUSTOMARY CHARGES				
15	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS				15
16	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)				16
17	RATIO OF LINE 15 TO LINE 16 (not to exceed 1.000000)	1.000000			17
18	TOTAL CUSTOMARY CHARGES (see instructions)	284,774			18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 18 exceeds line 11 (see instructions))	191,847			19
20	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (complete only if line 11 exceeds line 18 (see instructions))				20
21	LESSER OF COST OR CHARGES (line 11 minus line 20) (for CAH, see instructions)	92,927			21
22	INTERNS AND RESIDENTS (see instructions)				22
23	COST OF TEACHING PHYSICIANS (see instructions, 42 CFR 415.160 and CMS PUB. 15-1 §2148)				23
24	TOTAL PROSPECTIVE PAYMENT (sum of lines 3, 4, 8 and 9)	23,122,474			24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	DEDUCTIBLES AND COINSURANCE (see instructions)				25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (see instructions)	5,232,227			26
27	SUBTOTAL {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (see instructions)	17,983,174			27
28	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Wkst E-4, line 50)				28
29	ESRD DIRECT MEDICAL EDUCATION COSTS (from Wkst E-4, line 36)				29
30	SUBTOTAL (sum of lines 27 through 29)	17,983,174			30
31	PRIMARY PAYER PAYMENTS	3,234			31
32	SUBTOTAL (line 30 minus line 31)	17,979,940			32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	COMPOSITE RATE ESRD (from Wkst I-5, line 11)				33
34	ALLOWABLE BAD DEBTS (see instructions)	401,566			34
35	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	261,018			35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	277,115			36
37	SUBTOTAL (see instructions)	18,240,958			37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R				38
39	OTHER ADJUSTMENTS (SPECIFY) (see instructions)				39
40	SUBTOTAL (see instructions)	18,240,958			40
40.01	SEQUESTRATION ADJUSTMENT (see instructions)	275,438			40.01
41	INTERIM PAYMENTS	17,877,200			41
42	TENTATIVE SETTLEMENT (for contractor use only)				42
43	BALANCE DUE PROVIDER/PROGRAM (see instructions)	88,320			43
44	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2				44

TO BE COMPLETED BY CONTRACTOR

90	ORIGINAL OUTLIER AMOUNT (see instructions)				90
91	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (see instructions)				91
92	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY				92
93	TIME VALUE OF MONEY (see instructions)				93
94	TOTAL (sum of lines 91 and 93)				94



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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-S062

WORKSHEET E
PART B

CHECK APPLICABLE BOX: [] HOSPITAL [XX] IPF [] IRF [] SUB (OTHER) [] SNF

PART B - MEDICAL AND OTHER HEALTH SERVICES

		1	1.01	1.02	
1	MEDICAL AND OTHER SERVICES (see instructions)				1
2	MEDICAL AND OTHER SERVICES REIMBURSED UNDER OPPTS (see instructions)				2
3	PPS PAYMENTS				3
4	OUTLIER PAYMENT (see instructions)				4
5	ENTER THE HOSPITAL SPECIFIC PAYMENT TO COST RATIO (see instructions)				5
6	LINE 2 TIMES LINE 5				6
7	SUM OF LINE 3 PLUS LINE 4 DIVIDED BY LINE 6				7
8	TRANSITIONAL CORRIDOR PAYMENT (see instructions)				8
9	ANCILLARY SERVICE OTHER PASS THROUGH COSTS FROM WKST D, PART IV, COL. 13, LINE 200				9
10	ORGAN ACQUISITION				10
11	TOTAL COST (sum of lines 1 and 10) (see instructions)				11
	COMPUTATION OF LESSER OF COST OR CHARGES				
	REASONABLE CHARGES				
12	ANCILLARY SERVICE CHARGES				12
13	ORGAN ACQUISITION CHARGES (from Wkst D-4, Part III, line 69, col. 4)				13
14	TOTAL REASONABLE CHARGES (sum of lines 12 and 13)				14
	CUSTOMARY CHARGES				
15	AGGREGATE AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS				15
16	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)				16
17	RATIO OF LINE 15 TO LINE 16 (not to exceed 1.000000)	1.000000			17
18	TOTAL CUSTOMARY CHARGES (see instructions)				18
19	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 18 exceeds line 11 (see instructions))				19
20	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (complete only if line 11 exceeds line 18 (see instructions))				20
21	LESSER OF COST OR CHARGES (line 11 minus line 20) (for CAH, see instructions)				21
22	INTERNS AND RESIDENTS (see instructions)				22
23	COST OF TEACHING PHYSICIANS (see instructions, 42 CFR 415.160 and CMS PUB. 15-1 §2148)				23
24	TOTAL PROSPECTIVE PAYMENT (sum of lines 3, 4, 8 and 9)				24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25	DEDUCTIBLES AND COINSURANCE (see instructions)				25
26	DEDUCTIBLES AND COINSURANCE RELATING TO AMOUNT ON LINE 24 (see instructions)				26
27	SUBTOTAL {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (see instructions)				27
28	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Wkst E-4, line 50)				28
29	ESRD DIRECT MEDICAL EDUCATION COSTS (from Wkst E-4, line 36)				29
30	SUBTOTAL (sum of lines 27 through 29)				30
31	PRIMARY PAYER PAYMENTS				31
32	SUBTOTAL (line 30 minus line 31)				32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33	COMPOSITE RATE ESRD (from Wkst I-5, line 11)				33
34	ALLOWABLE BAD DEBTS (see instructions)				34
35	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)				35
36	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)				36
37	SUBTOTAL (see instructions)				37
38	MSP-LCC RECONCILIATION AMOUNT FROM PS&R				38
39	OTHER ADJUSTMENTS (SPECIFY) (see instructions)				39
40	SUBTOTAL (see instructions)				40
40.01	SEQUESTRATION ADJUSTMENT (see instructions)				40.01
41	INTERIM PAYMENTS				41
42	TENTATIVE SETTLEMENT (for contractor use only)				42
43	BALANCE DUE PROVIDER/PROGRAM (see instructions)				43
44	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB. 15-II, SECTION 115.2				44

TO BE COMPLETED BY CONTRACTOR

90	ORIGINAL OUTLIER AMOUNT (see instructions)				90
91	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (see instructions)				91
92	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY				92
93	TIME VALUE OF MONEY (see instructions)				93
94	TOTAL (sum of lines 91 and 93)				94



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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 14-0062

WORKSHEET E-1
PART I

CHECK HOSPITAL SUB (OTHER)
 APPLICABLE IPF SNF
 BOXES: IRF SWING BED SNF

		INPATIENT PART A		PART B	
DESCRIPTION		mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT
		1	2	3	4
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER		75,322,638		17,662,734
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO		467,422		204,234
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT			07/01/2013	10,232
	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)				
		.01			3.01
		.02			3.02
	PROGRAM	.03			3.03
	TO	.04			3.04
	PROVIDER	.05			3.05
		.06			3.06
		.07			3.07
		.08			3.08
		.09			3.09
		.10			3.10
		.50			3.50
		.51	07/01/2013	45,560	3.51
	PROVIDER	.52			3.52
	TO	.53			3.53
	PROGRAM	.54			3.54
		.55			3.55
		.56			3.56
		.57			3.57
		.58			3.58
		.59			3.59
	SUBTOTAL (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	.99	-45,560		10,232
4	TOTAL INTERIM PAYMENTS (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		75,744,500		17,877,200
TO BE COMPLETED BY CONTRACTOR					
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)				
		.01			5.01
		.02			5.02
	PROGRAM	.03			5.03
	TO	.04			5.04
	PROVIDER	.05			5.05
		.06			5.06
		.07			5.07
		.08			5.08
		.09			5.09
		.10			5.10
		.50			5.50
		.51			5.51
	PROVIDER	.52			5.52
	TO	.53			5.53
	PROGRAM	.54			5.54
		.55			5.55
		.56			5.56
		.57			5.57
		.58			5.58
		.59			5.59
	SUBTOTAL (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99			5.99
6	DETERMINED NET SETTLEMENT AMOUNT (balance due) BASED ON THE COST REPORT (1)	.01	1,264,485		363,758
		.02			6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)		77,008,985		18,240,958
8	NAME OF CONTRACTOR		CONTRACTOR NUMBER		NPR DATE (Month/Day/Year)

(1) On lines 3, 5, and 6, where an amount is due provider to program, show the amount and date on which the provider agrees to the amount of repayment even though total repayment is not accomplished until a later date.



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ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

COMPONENT CCN: 14-S062

WORKSHEET E-1
PART I

CHECK [] HOSPITAL [] SUB (OTHER)
 APPLICABLE [XX] IPF [] SNF
 BOXES: [] IRF [] SWING BED SNF

		INPATIENT PART A		PART B	
DESCRIPTION		mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT
		1	2	3	4
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER		1,827,697		1
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO				2
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT				
		.01			3.01
	AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM	.02			3.02
	RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF	PROGRAM .03			3.03
	EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	TO .04			3.04
		PROVIDER .05			3.05
		.06			3.06
		.07			3.07
		.08			3.08
		.09			3.09
		.10			3.10
		.50			3.50
		.51			3.51
		PROVIDER .52			3.52
		TO .53			3.53
		PROGRAM .54			3.54
		.55			3.55
		.56			3.56
		.57			3.57
		.58			3.58
		.59			3.59
	SUBTOTAL (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	.99			3.99
4	TOTAL INTERIM PAYMENTS (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1,827,697		4
TO BE COMPLETED BY CONTRACTOR					
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT	.01			5.01
	AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT.	.02			5.02
	IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	PROGRAM .03			5.03
		TO .04			5.04
		PROVIDER .05			5.05
		.06			5.06
		.07			5.07
		.08			5.08
		.09			5.09
		.10			5.10
		.50			5.50
		.51			5.51
		PROVIDER .52			5.52
		TO .53			5.53
		PROGRAM .54			5.54
		.55			5.55
		.56			5.56
		.57			5.57
		.58			5.58
		.59			5.59
	SUBTOTAL (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)	.99			5.99
6	DETERMINED NET SETTLEMENT AMOUNT (balance due)	.01	81,967		6.01
	BASED ON THE COST REPORT (1)	.02			6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)		1,909,664		7
8	NAME OF CONTRACTOR	CONTRACTOR NUMBER		NPR DATE (Month/Day/Year)	
					8

(1) On lines 3, 5, and 6, where an amount is due provider to program, show the amount and date on which the provider agrees to the amount of repayment even though total repayment is not accomplished until a later date.



COMPU-MAX

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CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT

WORKSHEET E-1
PART II

CHECK HOSPITAL CAH
 APPLICABLE BOX:

TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS

HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION

1	TOTAL HOSPITAL DISCHARGES AS DEFINED IN AARA §4102 FROM WKST S-3, PART I, COLUMN 15, LINE 14	15,869	1
2	MEDICARE DAYS FROM WKST S-3, PART I, COLUMN 6, SUM OF LINES 1, 8-12	47,319	2
3	MEDICARE HMO DAYS FROM WKST S-3, PART I, COLUMN 6, LINE 2	2,907	3
4	TOTAL INPATIENT DAYS FROM S-3, PART I, COLUMN 8, SUM OF LINES 1, 8-12	72,467	4
5	TOTAL HOSPITAL CHARGES FROM WKST C, PART I, COLUMN 8, LINE 200	1,253,120,619	5
6	TOTAL HOSPITAL CHARITY CARE CHARGES FROM WKST S-10, COLUMN 3, LINE 20	25,029,111	6
7	CAH ONLY - THE REASONABLE COST INCURRED FOR THE PURCHASE OF CERTIFIED HIT TECHNOLOGY FROM WORKSHEET S-2, PART I, LINE 168		7
8	CALCULATION OF THE HIT INCENTIVE PAYMENT (see instructions)	3,496,397	8
9	SEQUESTRATION ADJUSTMENT AMOUNT (see instructions)	69,928	9
10	CALCULATION OF THE HIT INCENTIVE PAYMENT AFTER SEQUESTRATION (see instructions)	3,426,469	10

INPATIENT HOSPITAL SERVICES UNDER PPS & CAH

30	INITIAL/INTERIM HIT PAYMENT(S)	3,485,150	30
31	OTHER ADJUSTMENTS ()		31
32	BALANCE DUE PROVIDER (line 8 (or line 10) minus line 30 and line 31) (see instructions)	-58,681	32



COMPU-MAX

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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-S062

WORKSHEET E-3
PART II

CHECK [] HOSPITAL
 APPLICABLE [XX] SUBPROVIDER IPF
 BOX:

PART II - CALCULATION OF MEDICARE REIMBURSEMENT SETTLEMENT UNDER IPF PPS

1	NET FEDERAL IPF PPS PAYMENT (excluding outlier, ECT, and medical education payments)	2,073,682	1
2	NET IPF PPS OUTLIER PAYMENT	73,930	2
3	NET IPF PPS ECT PAYMENT		3
4	UNWEIGHTED INTERN AND RESIDENT FTE COUNT IN THE MOST RECENT COST REPORT FILED ON OR BEFORE NOVEMBER 15, 2004		4
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)		4.01
5	NEW TEACHING PROGRAM ADJUSTMENT (see instructions)		5
6	CURRENT YEAR UNWEIGHTED FTE COUNT OF I&R EXCLUDING FTEs IN THE NEW PROGRAM GROWTH PERIOD OF A 'NEW TEACHING PROGRAM (see instructions)		6
7	CURRENT YEAR UNWEIGHTED I&R FTE COUNT FOR RESIDENTS WITHIN THE NEW PROGRAM GROWTH PERIOD OF A 'NEW TEACHING PROGRAM (see instructions)		7
8	INTERN AND RESIDENT COUNT FOR IPF PPS MEDICAL EDUCATION ADJUSTMENT (see instructions)		8
9	AVERAGE DAILY CENSUS (see instructions)	18,339,726	9
10	TEACHING ADJUSTMENT FACTOR $\{(1 + (\text{line } 8/\text{line } 9)) \text{ raised to the power of } .5150 - 1\}$		10
11	TEACHING ADJUSTMENT (line 1 multiplied by line 10)		11
12	ADJUSTED NET IPF PPS PAYMENTS (sum of lines 1, 2, 3 and 11)	2,147,612	12
13	NURSING AND ALLIED HEALTH MANAGED CARE PAYMENT (see instructions)		13
14	ORGAN ACQUISITION		14
15	COST OF TEACHING PHYSICIANS (from Worksheet D-5, Part II, col. 3, line 20) (see instructions)		15
16	SUBTOTAL (see instructions)	2,147,612	16
17	PRIMARY PAYER PAYMENTS	957	17
18	SUBTOTAL (line 16 less line 17)	2,146,655	18
19	DEDUCTIBLES	221,324	19
20	SUBTOTAL (line 18 minus line 19)	1,925,331	20
21	COINSURANCE	67,784	21
22	SUBTOTAL (line 20 minus line 21)	1,857,547	22
23	ALLOWABLE BAD DEBTS (exclude bad debts for professional services) (see instructions)	78,965	23
24	ADJUSTED REIMBURSABLE BAD DEBTS (see instructions)	51,327	24
25	ALLOWABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)	78,965	25
26	SUBTOTAL (sum of lines 22 and 24)	1,908,874	26
27	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Worksheet E-4, line 49) (for freestanding IPF only)		27
28	OTHER PASS THROUGH COSTS (see instructions)	790	28
29	OUTLIER PAYMENTS RECONCILIATION		29
30	OTHER ADJUSTMENTS (SPECIFY) (see instructions)		30
31	TOTAL AMOUNT PAYABLE TO THE PROVIDER (see instructions)	1,909,664	31
31.01	SEQUESTRATION ADJUSTMENT (see instructions)	28,836	31.01
32	INTERIM PAYMENTS	1,827,697	32
33	TENTATIVE SETTLEMENT (for contractor use only)		33
34	BALANCE DUE PROVIDER/PROGRAM (line 31 minus lines 31.01, 32 and 33)	53,131	34
35	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2		35

TO BE COMPLETED BY CONTRACTOR

50	ORIGINAL OUTLIER AMOUNT FROM WORKSHEET E-3, PART II, LINE 2 (see instructions)		50
51	OUTLIER RECONCILIATION ADJUSTMENT AMOUNT (see instructions)		51
52	THE RATE USED TO CALCULATE THE TIME VALUE OF MONEY (see instructions)		52
53	TIME VALUE OF MONEY (see instructions)		53



COMPU-MAX

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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-0062

WORKSHEET E-3
PART VII

CHECK TITLE V HOSPITAL NF PPS
 APPLICABLE TITLE XIX SUB (OTHER) ICF/MR TEFRA
 BOXES: SNF OTHER

PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR TITLE XIX SERVICES

		INPATIENT TITLE V OR TITLE XIX	OUTPAT- IENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	INPATIENT HOSPITAL SNF/NF SERVICES			1
2	MEDICAL AND OTHER SERVICES			2
3	ORGAN ACQUISITION (certified transplant centers only)			3
4	SUBTOTAL (sum of lines 1, 2 and 3)			4
5	INPATIENT PRIMARY PAYER PAYMENTS			5
6	OUTPATIENT PRIMARY PAYER PAYMENTS			6
7	SUBTOTAL (line 4 less sum of lines 5 and 6)			7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	ROUTINE SERVICE CHARGES			8
9	ANCILLARY SERVICE CHARGES	19,238,819		9
10	ORGAN ACQUISITION CHARGES, NET OF REVENUE			10
11	INCENTIVE FROM TARGET AMOUNT COMPUTATION			11
12	TOTAL REASONABLE CHARGES (sum of lines 8-11)	19,238,819		12
	CUSTOMARY CHARGES			
13	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS			13
14	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)			14
15	RATIO OF LINE 13 TO LINE 14 (not to exceed 1.000000)	1	1	15
16	TOTAL CUSTOMARY CHARGES (see instructions)	19,238,819		16
17	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 16 exceeds line 4) (see instructions)	19,238,819		17
18	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (complete only if line 4 exceeds line 16) (see instructions)			18
19	INTERNS AND RESIDENTS (see instructions)			19
20	COST OF TEACHING PHYSICIANS (see instructions)			20
21	COST OF COVERED SERVICES (lesser of line 4 or line 16) (for CAH, see instructions)			21
	PROSPECTIVE PAYMENT AMOUNT			
22	OTHER THAN OUTLIER PAYMENTS			22
23	OUTLIER PAYMENTS			23
24	PROGRAM CAPITAL PAYMENTS			24
25	CAPITAL EXCEPTION PAYMENTS (see instructions)			25
26	ROUTINE AND ANCILLARY SERVICE OTHER PASS THROUGH COSTS	5,014		26
27	SUBTOTAL (sum of lines 22 through 26)	5,014		27
28	CUSTOMARY CHARGES (Titles V or XIX PPS covered services only)			28
29	SUM OF LINES 27 AND 21	5,014		29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	EXCESS OF REASONABLE COST (from line 18)			30
31	SUBTOTAL (sum of lines 19 and 20 plus 29 minus lines 5 and 6)	5,014		31
32	DEDUCTIBLES			32
33	COINSURANCE			33
34	ALLOWABLE BAD DEBTS (see instructions)			34
35	UTILIZATION REVIEW			35
36	SUBTOTAL (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33)	5,014		36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	SUBTOTAL (line 36 ± line 37)	5,014		38
39	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Worksheet E-4)			39
40	TOTAL AMOUNT PAYABLE TO THE PROVIDER (sum of lines 38 and 39)	5,014		40
41	INTERIM PAYMENTS			41
42	BALANCE DUE PROVIDER/PROGRAM (line 40 minus 41)	5,014		42
43	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2			43



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CALCULATION OF REIMBURSEMENT SETTLEMENT

COMPONENT CCN: 14-S062

WORKSHEET E-3
PART VII

CHECK TITLE V
 APPLICABLE TITLE XIX
 BOXES:

PPS
 TEFRA
 OTHER

PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR TITLE XIX SERVICES

		INPATIENT TITLE V OR TITLE XIX	OUTPAT- IENT TITLE V OR TITLE XIX	
	COMPUTATION OF NET COST OF COVERED SERVICES			
1	INPATIENT HOSPITAL SNF/NF SERVICES	585,795		1
2	MEDICAL AND OTHER SERVICES			2
3	ORGAN ACQUISITION (certified transplant centers only)			3
4	SUBTOTAL (sum of lines 1, 2 and 3)	585,795		4
5	INPATIENT PRIMARY PAYER PAYMENTS			5
6	OUTPATIENT PRIMARY PAYER PAYMENTS			6
7	SUBTOTAL (line 4 less sum of lines 5 and 6)	585,795		7
	COMPUTATION OF LESSER OF COST OR CHARGES			
	REASONABLE CHARGES			
8	ROUTINE SERVICE CHARGES			8
9	ANCILLARY SERVICE CHARGES			9
10	ORGAN ACQUISITION CHARGES, NET OF REVENUE			10
11	INCENTIVE FROM TARGET AMOUNT COMPUTATION			11
12	TOTAL REASONABLE CHARGES (sum of lines 8-11)			12
	CUSTOMARY CHARGES			
13	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS			13
14	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)			14
15	RATIO OF LINE 13 TO LINE 14 (not to exceed 1.000000)	1	1	15
16	TOTAL CUSTOMARY CHARGES (see instructions)			16
17	EXCESS OF CUSTOMARY CHARGES OVER REASONABLE COST (complete only if line 16 exceeds line 4) (see instructions)			17
18	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (complete only if line 4 exceeds line 16) (see instructions)	585,795		18
19	INTERNS AND RESIDENTS (see instructions)			19
20	COST OF TEACHING PHYSICIANS (see instructions)			20
21	COST OF COVERED SERVICES (lesser of line 4 or line 16) (for CAH, see instructions)			21
	PROSPECTIVE PAYMENT AMOUNT			
22	OTHER THAN OUTLIER PAYMENTS			22
23	OUTLIER PAYMENTS			23
24	PROGRAM CAPITAL PAYMENTS			24
25	CAPITAL EXCEPTION PAYMENTS (see instructions)			25
26	ROUTINE AND ANCILLARY SERVICE OTHER PASS THROUGH COSTS			26
27	SUBTOTAL (sum of lines 22 through 26)			27
28	CUSTOMARY CHARGES (Titles V or XIX PPS covered services only)			28
29	SUM OF LINES 27 AND 21			29
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30	EXCESS OF REASONABLE COST (from line 18)			30
31	SUBTOTAL (sum of lines 19 and 20 plus 29 minus lines 5 and 6)			31
32	DEDUCTIBLES			32
33	COINSURANCE			33
34	ALLOWABLE BAD DEBTS (see instructions)			34
35	UTILIZATION REVIEW			35
36	SUBTOTAL (sum of lines 31, 34 and 35 minus the sum of lines 32 and 33)			36
37	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			37
38	SUBTOTAL (line 36 ± line 37)			38
39	DIRECT GRADUATE MEDICAL EDUCATION PAYMENTS (from Worksheet E-4)			39
40	TOTAL AMOUNT PAYABLE TO THE PROVIDER (sum of lines 38 and 39)			40
41	INTERIM PAYMENTS			41
42	BALANCE DUE PROVIDER/PROGRAM (line 40 minus 41)			42
43	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115.2			43



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BALANCE SHEET

WORKSHEET G

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

ASSETS (Omit Cents)		GENERAL FUND 1	SPECIFIC PURPOSE FUND 2	ENDOWMENT FUND 3	PLANT FUND 4	
CURRENT ASSETS						
1	CASH ON HAND AND IN BANKS	16,039,000				1
2	TEMPORARY INVESTMENTS	12,654,000				2
3	NOTES RECEIVABLE					3
4	ACCOUNTS RECEIVABLE	159,494,000				4
5	OTHER RECEIVABLES					5
6	ALLOWANCES FOR UNCOLLECTIBLE NOTES AND ACCOUNTS RECEIVABLE	-124,915,000				6
7	INVENTORY	1,833,000				7
8	PREPAID EXPENSES					8
9	OTHER CURRENT ASSETS	44,585,000				9
10	DUE FROM OTHER FUNDS					10
11	TOTAL CURRENT ASSETS (sum of lines 1-10)	109,690,000				11
FIXED ASSETS						
12	LAND	7,365,000				12
13	LAND IMPROVEMENTS	6,911,000				13
14	ACCUMULATED DEPRECIATION	-5,656,000				14
15	BUILDINGS	394,128,000				15
16	ACCUMULATED DEPRECIATION	-111,388,000				16
17	LEASEHOLD IMPROVEMENTS	30,469,000				17
18	ACCUMULATED AMORTIZATION					18
19	FIXED EQUIPMENT					19
20	ACCUMULATED DEPRECIATION					20
21	AUTOMOBILES AND TRUCKS					21
22	ACCUMULATED DEPRECIATION					22
23	MAJOR MOVABLE EQUIPMENT	196,916,000				23
24	ACCUMULATED DEPRECIATION	-130,519,000				24
25	MINOR EQUIPMENT DEPRECIABLE					25
26	ACCUMULATED DEPRECIATION					26
27	HIT DESIGNATED ASSETS					27
28	ACCUMULATED DEPRECIATION					28
29	MINOR EQUIPMENT-NONDEPRECIABLE					29
30	TOTAL FIXED ASSETS (sum of lines 12-29)	388,226,000				30
OTHER ASSETS						
31	INVESTMENTS	321,838,000				31
32	DEPOSITS ON LEASES					32
33	DUE FROM OWNERS/OFFICERS					33
34	OTHER ASSETS	10,793,000				34
35	TOTAL OTHER ASSETS (sum of lines 31-34)	332,631,000				35
36	TOTAL ASSETS (sum of lines 11, 30 and 35)	830,547,000				36
LIABILITIES AND FUND BALANCES (Omit Cents)		GENERAL FUND 1	SPECIFIC PURPOSE FUND 2	ENDOWMENT FUND 3	PLANT FUND 4	
CURRENT LIABILITIES						
37	ACCOUNTS PAYABLE	19,097,000				37
38	SALARIES, WAGES & FEES PAYABLE	25,850,000				38
39	PAYROLL TAXES PAYABLE					39
40	NOTES & LOANS PAYABLE (short term)					40
41	DEFERRED INCOME					41
42	ACCELERATED PAYMENTS					42
43	DUE TO OTHER FUNDS					43
44	OTHER CURRENT LIABILITIES	83,078,000				44
45	TOTAL CURRENT LIABILITIES (sum of lines 37 thru 44)	128,025,000				45
LONG TERM LIABILITIES						
46	MORTGAGE PAYABLE	338,351,000				46
47	NOTES PAYABLE					47
48	UNSECURED LOANS					48
49	OTHER LONG TERM LIABILITIES	40,983,000				49
50	TOTAL LONG TERM LIABILITIES (sum of lines 46 thru 49)	379,334,000				50
51	TOTAL LIABILITIES (sum of lines 45 and 50)	507,359,000				51
CAPITAL ACCOUNTS						
52	GENERAL FUND BALANCE	323,188,000				52
53	SPECIFIC PURPOSE FUND BALANCE					53
54	DONOR CREATED - ENDOWMENT FUND BALANCE - RESTRICTED					54
55	DONOR CREATED - ENDOWMENT FUND BALANCE - UNRESTRICTED					55
56	GOVERNING BODY CREATED - ENDOWMENT FUND BALANCE					56
57	PLANT FUND BALANCE - INVESTED IN PLANT					57
58						



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STATEMENT OF CHANGES IN FUND BALANCES

WORKSHEET G-1

		GENERAL FUND		SPECIFIC PURPOSE FUND		
		1	2	3	4	
1	FUND BALANCES AT BEGINNING OF PERIOD		291,280,850			1
2	NET INCOME (loss) (from Worksheet G-3, line 29)		7,583,684			2
3	TOTAL (sum of line 1 and line 2)		298,864,534			3
4	ADDITIONS (credit adjustments)					4
5	CONTRIBUTIONS	687,223				5
6	UNREALIZED GAINS	23,636,243				6
7						7
8						8
9						9
10	TOTAL ADDITIONS (sum of lines 4-9)		24,323,466			10
11	SUBTOTAL (line 3 plus line 10)		323,188,000			11
12	DEDUCTIONS (debit adjustments)					12
13	UNREALIZED LOSSES					13
14						14
15						15
16						16
17						17
18	TOTAL DEDUCTIONS (sum of lines 12-17)					18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (line 11 minus line 18)		323,188,000			19

		ENDOWMENT FUND		PLANT FUND		
		5	6	7	8	
1	FUND BALANCES AT BEGINNING OF PERIOD					1
2	NET INCOME (loss) (from Worksheet G-3, line 29)					2
3	TOTAL (sum of line 1 and line 2)					3
4	ADDITIONS (credit adjustments)					4
5	CONTRIBUTIONS					5
6	UNREALIZED GAINS					6
7						7
8						8
9						9
10	TOTAL ADDITIONS (sum of lines 4-9)					10
11	SUBTOTAL (line 3 plus line 10)					11
12	DEDUCTIONS (debit adjustments)					12
13	UNREALIZED LOSSES					13
14						14
15						15
16						16
17						17
18	TOTAL DEDUCTIONS (sum of lines 12-17)					18
19	FUND BALANCE AT END OF PERIOD PER BALANCE SHEET (line 11 minus line 18)					19



PALOS COMMUNITY HOSPITAL Provider CCN: 14-0062	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 08:45 Version: 2014.03
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STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

WORKSHEET G-2
PARTS I & II

PART I - PATIENT REVENUES

	REVENUE CENTER	INPATIENT	OUTPATIENT	TOTAL	
		1	2	3	
	GENERAL INPATIENT ROUTINE CARE SERVICES				
1	HOSPITAL	121,226,529		121,226,529	1
2	SUBPROVIDER IPF	12,801,998		12,801,998	2
3	SUBPROVIDER IRF				3
5	SWING BED - SNF				5
6	SWING BED - NF				6
7	SKILLED NURSING FACILITY				7
8	NURSING FACILITY				8
9	OTHER LONG TERM CARE				9
10	TOTAL GENERAL INPATIENT CARE SERVICES (sum of lines 1-9)	134,028,527		134,028,527	10
	INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES				
11	INTENSIVE CARE UNIT				11
12	CORONARY CARE UNIT				12
13	BURN INTENSIVE CARE UNIT				13
14	SURGICAL INTENSIVE CARE UNIT				14
15	OTHER SPECIAL CARE (SPECIFY)				15
16	TOTAL INTENSIVE CARE TYPE INPATIENT HOSPITAL SERVICES (sum of lines 11-15)				16
17	TOTAL INPATIENT ROUTINE CARE SERVICES (sum of lines 10 and 16)	134,028,527		134,028,527	17
18	ANCILLARY SERVICES	517,440,977		517,440,977	18
19	OUTPATIENT SERVICES		579,971,484	579,971,484	19
20	RHC				20
21	FQHC				21
22	HOME HEALTH AGENCY		15,172,868	15,172,868	22
23	AMBULANCE				23
25	ASC				25
26	HOSPICE				26
27	OTHER (SPECIFY)				27
27.01	PHYSICIAN SERVICE	4,433,426		4,433,426	27.01
27.02	HOSPICE		9,050,126	9,050,126	27.02
27.03	PRIVATE DUTY		1,009,653	1,009,653	27.03
28	TOTAL PATIENT REVENUES (sum of lines 17-27) (transfer column 3 to Worksheet G-3, line 1)	655,902,930	605,204,131	1,261,107,061	28

PART II - OPERATING EXPENSES

		1	2	
29	OPERATING EXPENSES (per Worksheet A, column 3, line 200)		342,883,258	29
30	ADD (SPECIFY)			30
31				31
32				32
33				33
34				34
35				35
36	TOTAL ADDITIONS (sum of lines 30-35)			36
37	DEDUCT (SPECIFY)			37
38				38
39				39
40				40
41				41
42	TOTAL DEDUCTIONS (sum of lines 37-41)			42
43	TOTAL OPERATING EXPENSES (sum of lines 29 and 36 minus line 42) (transfer to Worksheet G-3, line 4)		342,883,258	43



COMPU-MAX

PALOS COMMUNITY HOSPITAL Provider CCN: 14-0062	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 08:45 Version: 2014.03
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STATEMENT OF REVENUES AND EXPENSES

WORKSHEET G-3

	DESCRIPTION		
1	TOTAL PATIENT REVENUES (from Worksheet G-2, Part I, column 3, line 28)	1,261,107.061	1
2	LESS - CONTRACTUAL ALLOWANCES AND DISCOUNTS ON PATIENTS' ACCOUNTS	945,820,348	2
3	NET PATIENT REVENUES (line 1 minus line 2)	315,286,713	3
4	LESS - TOTAL OPERATING EXPENSES (from Worksheet G-2, Part II, line 43)	342,883,258	4
5	NET INCOME FROM SERVICE TO PATIENTS (line 3 minus line 4)	-27,596,545	5

OTHER INCOME

6	CONTRIBUTIONS, DONATIONS, BEQUESTS, ETC.		6
7	INCOME FROM INVESTMENTS	25,563,853	7
8	REVENUES FROM TELEPHONE AND OTHER MISCELLANEOUS COMMUNICATION SERVICES		8
9	REVENUE FROM TELEVISION AND RADIO SERVICE		9
10	PURCHASE DISCOUNTS	39,850	10
11	REBATES AND REFUNDS OF EXPENSES		11
12	PARKING LOT RECEIPTS		12
13	REVENUE FROM LAUNDRY AND LINEN SERVICE		13
14	REVENUE FROM MEALS SOLD TO EMPLOYEES AND GUESTS	1,027,196	14
15	REVENUE FROM RENTAL OF LIVING QUARTERS		15
16	REVENUE FROM SALE OF MEDICAL AND SURGICAL SUPPLIES TO OTHER THAN PATIENTS		16
17	REVENUE FROM SALE OF DRUGS TO OTHER THAN PATIENTS		17
18	REVENUE FROM SALE OF MEDICAL RECORDS AND ABSTRACTS	227,192	18
19	TUITION (fees, sale of textbooks, uniforms, etc.)		19
20	REVENUE FROM GIFTS, FLOWER, COFFEE SHOPS, CANTEEN		20
21	RENTAL OF VENDING MACHINES	15,363	21
22	RENTAL OF HOSPITAL SPACE	1,322,040	22
23	GOVERNMENTAL APPROPRIATIONS		23
24	OTHER (COMMUNITY EDUCATION)	41,162	24
24.01	OTHER (MISCELLANEOUS)	4,484,595	24.01
24.02	OTHER (HOME DELIVERED MEALS)	51,899	24.02
24.03	OTHER (LIFELINE)	55,259	24.03
24.05	OTHER (BABY PHOTO)	1,420	24.05
24.06	OTHER (OTHER)	2,350,400	24.06
25	TOTAL OTHER INCOME (sum of lines 6-24)	35,180,229	25
26	TOTAL (line 5 plus line 25)	7,583,684	26
29	NET INCOME (or loss) FOR THE PERIOD (line 26 minus line 28)	7,583,684	29



COMPU-MAX

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ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA CCN: 14-7470

WORKSHEET H

	COST CENTER DESCRIPTIONS (omit cents)	SALARIES	EMPLOYEE BENEFITS	TRANSPOR- TATION (see ins- tructions)	CONTRACTED/ PURCHASED SERVICES	OTHER COSTS	
		1	2	3	4	5	
	GENERAL SERVICE COST CENTER						
1	CAPITAL RELATED-BLDGS & FIXTURES						1
2	CAPITAL RELATED-MOVABLE EQUIPMENT						2
3	PLANT OPERATION & MAINTENANCE						3
4	TRANSPORTATION (see instructions)						4
5	ADMINISTRATIVE AND GENERAL	2,151,985		300,329		468,556	5
	HHA REIMBURSABLE SERVICES						
6	SKILLED NURSING CARE	3,728,272				162,155	6
7	PHYSICAL THERAPY	962,046			714,338		7
8	OCCUPATIONAL THERAPY	198,014			95,896		8
9	SPEECH PATHOLOGY	55,058			52,973		9
10	MEDICAL SOCIAL SERVICES	84,680					10
11	HOME HEALTH AIDE	685,224					11
12	SUPPLIES (see instructions)					85,222	12
13	DRUGS					4,870	13
14	DME						14
	HHA NONREIMBURSABLE SERVICES						
15	HOME DIALYSIS AIDE SERVICES						15
16	RESPIRATORY THERAPY						16
17	PRIVATE DUTY NURSING						17
18	CLINIC						18
19	HEALTH PROMOTION ACTIVITIES						19
20	DAY CARE PROGRAM						20
21	HOME DELIVERED MEALS PROGRAM						21
22	HOMEMAKER SERVICE						22
23	ALL OTHERS						23
23.50	TELEMEDICINE						23.50
24	TOTAL (sum of lines 1-23)	7,865,279		300,329	863,207	720,803	24



COMPU-MAX

PALOS COMMUNITY HOSPITAL Provider CCN: 14-0062	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 08:45 Version: 2014.03
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ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA CCN: 14-7470

WORKSHEET H

	COST CENTER DESCRIPTIONS (omit cents)	TOTAL (sum of cols. 1 thru 5)	RECLASS- IFICATIONS	RECLASSIFIED TRIAL BALANCE (col. 6 + col. 7)	ADJUSTMENTS	NET EXPENSES FOR ALLOCATION (col. 8 + col. 9)	
		6	7	8	9	10	
	GENERAL SERVICE COST CENTER						
1	CAPITAL RELATED-BLDGS & FIXTURES						1
2	CAPITAL RELATED-MOVABLE EQUIPMENT						2
3	PLANT OPERATION & MAINTENANCE						3
4	TRANSPORTATION (see instructions)						4
5	ADMINISTRATIVE AND GENERAL	2,920,870	8,333	2,929,203	-1,353	2,927,850	5
	HHA REIMBURSABLE SERVICES						
6	SKILLED NURSING CARE	3,890,427		3,890,427		3,890,427	6
7	PHYSICAL THERAPY	1,676,384		1,676,384		1,676,384	7
8	OCCUPATIONAL THERAPY	293,910		293,910		293,910	8
9	SPEECH PATHOLOGY	108,031		108,031		108,031	9
10	MEDICAL SOCIAL SERVICES	84,680		84,680		84,680	10
11	HOME HEALTH AIDE	685,224		685,224		685,224	11
12	SUPPLIES (see instructions)	85,222		85,222		85,222	12
13	DRUGS	4,870		4,870		4,870	13
14	DME						14
	HHA NONREIMBURSABLE SERVICES						
15	HOME DIALYSIS AIDE SERVICES						15
16	RESPIRATORY THERAPY						16
17	PRIVATE DUTY NURSING						17
18	CLINIC						18
19	HEALTH PROMOTION ACTIVITIES						19
20	DAY CARE PROGRAM						20
21	HOME DELIVERED MEALS PROGRAM						21
22	HOMEMAKER SERVICE						22
23	ALL OTHERS						23
23.50	TELEMEDICINE						23.50
24	TOTAL (sum of lines 1-23)	9,749,618	8,333	9,757,951	-1,353	9,756,598	24

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



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ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA CCN: 14-7470

WORKSHEET H-1
PART I

		NET EXPENSES FOR COST ALLOCATION (from Wkst. H, col. 10)	CAPITAL RELATED COSTS			
			BLDGS. & FIXTURES	MOVABLE EQUIPMENT	PLANT OPERATION & MAINTENANCE	
		0	1	2	3	
GENERAL SERVICE COST CENTER						
1	CAPITAL RELATED-BLDGS & FIXTURES					1
2	CAPITAL RELATED-MOVABLE EQUIPMENT					2
3	PLANT OPERATION & MAINTENANCE					3
4	TRANSPORTATION (see instructions)					4
5	ADMINISTRATIVE AND GENERAL	2,927,850				5
HHA REIMBURSABLE SERVICES						
6	SKILLED NURSING CARE	3,890,427				6
7	PHYSICAL THERAPY	1,676,384				7
8	OCCUPATIONAL THERAPY	293,910				8
9	SPEECH PATHOLOGY	108,031				9
10	MEDICAL SOCIAL SERVICES	84,680				10
11	HOME HEALTH AIDE	685,224				11
12	SUPPLIES (see instructions)	85,222				12
13	DRUGS	4,870				13
14	DME					14
HHA NONREIMBURSABLE SERVICES						
15	HOME DIALYSIS AIDE SERVICES					15
16	RESPIRATORY THERAPY					16
17	PRIVATE DUTY NURSING					17
18	CLINIC					18
19	HEALTH PROMOTION ACTIVITIES					19
20	DAY CARE PROGRAM					20
21	HOME DELIVERED MEALS PROGRAM					21
22	HOMEMAKER SERVICE					22
23	ALL OTHERS					23
23.50	TELEMEDICINE					23.50
24	TOTAL (sum of lines 1-23)	9,756,598				24



COMPU-MAX

PALOS COMMUNITY HOSPITAL Provider CCN: 14-0062	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 08:45 Version: 2014.03
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ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

HHA CCN: 14-7470

WORKSHEET H-1
PART I

		TRANSPORT- ATION	SUBTOTAL (cols. 0-4)	ADMINI- STRATIVE & GENERAL	TOTAL (col. 4A + 5)	
		4	4A	5	6	
	GENERAL SERVICE COST CENTER					
1	CAPITAL RELATED-BLDGS & FIXTURES					1
2	CAPITAL RELATED-MOVABLE EQUIPMENT					2
3	PLANT OPERATION & MAINTENANCE					3
4	TRANSPORTATION (see instructions)					4
5	ADMINISTRATIVE AND GENERAL		2,927,850	2,927,850		5
	HHA REIMBURSABLE SERVICES					
6	SKILLED NURSING CARE		3,890,427	1,668,033	5,558,460	6
7	PHYSICAL THERAPY		1,676,384	718,756	2,395,140	7
8	OCCUPATIONAL THERAPY		293,910	126,015	419,925	8
9	SPEECH PATHOLOGY		108,031	46,319	154,350	9
10	MEDICAL SOCIAL SERVICES		84,680	36,307	120,987	10
11	HOME HEALTH AIDE		685,224	293,793	979,017	11
12	SUPPLIES (see instructions)		85,222	36,539	121,761	12
13	DRUGS		4,870	2,088	6,958	13
14	DME					14
	HHA NONREIMBURSABLE SERVICES					
15	HOME DIALYSIS AIDE SERVICES					15
16	RESPIRATORY THERAPY					16
17	PRIVATE DUTY NURSING					17
18	CLINIC					18
19	HEALTH PROMOTION ACTIVITIES					19
20	DAY CARE PROGRAM					20
21	HOME DELIVERED MEALS PROGRAM					21
22	HOMEMAKER SERVICE					22
23	ALL OTHERS					23
23.50	TELEMEDICINE					23.50
24	TOTAL (sum of lines 1-23)		9,756,598		9,756,598	24



COMPU-MAX

PALOS COMMUNITY HOSPITAL Provider CCN: 14-0062	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 08:45 Version: 2014.03
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COST ALLOCATION - HHA STATISTICAL BASIS

HHA CCN: 14-7470

WORKSHEET H-1
PART II

		CAPITAL RELATED COSTS						
		BLDGS. & FIXTURES (Square Feet)	MOVABLE EQUIPMENT (Dollar Value)	PLANT OPERATION & MAINTENANCE (Square Feet)	TRANSPORTATION (Mileage)	RECONCILIATION	ADMINISTRATIVE & GENERAL (Accum. Cost)	
		1	2	3	4	5A	5	
GENERAL SERVICE COST CENTER								
1	CAPITAL RELATED-BLDGS & FIXTURES							1
2	CAPITAL RELATED-MOVABLE EQUIPMENT							2
3	PLANT OPERATION & MAINTENANCE							3
4	TRANSPORTATION (see instructions)							4
5	ADMINISTRATIVE AND GENERAL					-2,927,850	6,828,748	5
HHA REIMBURSABLE SERVICES								
6	SKILLED NURSING CARE						3,890,427	6
7	PHYSICAL THERAPY						1,676,384	7
8	OCCUPATIONAL THERAPY						293,910	8
9	SPEECH PATHOLOGY						108,031	9
10	MEDICAL SOCIAL SERVICES						84,680	10
11	HOME HEALTH AIDE						685,224	11
12	SUPPLIES (see instructions)						85,222	12
13	DRUGS						4,870	13
14	DME							14
HHA NONREIMBURSABLE SERVICES								
15	HOME DIALYSIS AIDE SERVICES							15
16	RESPIRATORY THERAPY							16
17	PRIVATE DUTY NURSING							17
18	CLINIC							18
19	HEALTH PROMOTION ACTIVITIES							19
20	DAY CARE PROGRAM							20
21	HOME DELIVERED MEALS PROGRAM							21
22	HOMEMAKER SERVICE							22
23	ALL OTHERS							23
23.50	TELEMEDICINE							23.50
24	TOTAL (sum of lines 1-23)					-2,927,850	6,828,748	24
25	COST TO BE ALLOC (per Worksheet H-1, Part I)						2,927,850	25
26	UNIT COST MULTIPLIER						0.428754	26



COMPU-MAX

PALOS COMMUNITY HOSPITAL Provider CCN: 14-0062	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 08:45 Version: 2014.03
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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA CCN: 14-7470

WORKSHEET H-2
PART I

	HHA COST CENTER (omit cents)	HHA TRIAL BALANCE(1)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	COMMUNI- CATIONS	DATA PROCESSING	
		0	1	2	4	5.01	5.02	
1	ADMINISTRATIVE AND GENERAL		6,761	68,961	2,545,265	38,092	104,145	1
2	SKILLED NURSING CARE	5,558,460						2
3	PHYSICAL THERAPY	2,395,140						3
4	OCCUPATIONAL THERAPY	419,925						4
5	SPEECH PATHOLOGY	154,350						5
6	MEDICAL SOCIAL SERVICES	120,987						6
7	HOME HEALTH AIDE	979,017						7
8	SUPPLIES	121,761						8
9	DRUGS	6,958						9
10	DME							10
11	HOME DIALYSIS AIDE SERVICES							11
12	RESPIRATORY THERAPY							12
13	PRIVATE DUTY NURSING							13
14	CLINIC							14
15	HEALTH PROMOTION ACTIVITIES							15
16	DAY CARE PROGRAM							16
17	HOME DELIVERED MEALS PROGRAM							17
18	HOMEMAKER SERVICE							18
19	ALL OTHERS							19
20	TOTALS (sum of lines 1-19)(2)	9,756,598	6,761	68,961	2,545,265	38,092	104,145	20
21	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

(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.



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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA CCN: 14-7470

WORKSHEET H-2
PART I

	HHA COST CENTER (omit cents)	PURCH & STORES	ADMITTING	CASHIERING	SUBTOTAL (cols.0-4)	ADMINIS- TRATIVE & GENERAL	MAIN- TENANCE & REPAIRS	
		5.03	5.04	5.05	4A	5.06	6	
1	ADMINISTRATIVE AND GENERAL	16,161			2,779,385	299,092	11,199	1
2	SKILLED NURSING CARE				5,558,460	598,151		2
3	PHYSICAL THERAPY				2,395,140	257,743		3
4	OCCUPATIONAL THERAPY				419,925	45,189		4
5	SPEECH PATHOLOGY				154,350	16,610		5
6	MEDICAL SOCIAL SERVICES				120,987	13,020		6
7	HOME HEALTH AIDE				979,017	105,353		7
8	SUPPLIES				121,761	13,103		8
9	DRUGS				6,958	749		9
10	DME							10
11	HOME DIALYSIS AIDE SERVICES							11
12	RESPIRATORY THERAPY							12
13	PRIVATE DUTY NURSING							13
14	CLINIC							14
15	HEALTH PROMOTION ACTIVITIES							15
16	DAY CARE PROGRAM							16
17	HOME DELIVERED MEALS PROGRAM							17
18	HOMEMAKER SERVICE							18
19	ALL OTHERS							19
20	TOTALS (sum of lines 1-19)(2)	16,161			12,535,983	1,349,010	11,199	20
21	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

(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.



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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA CCN: 14-7470

WORKSHEET H-2
PART I

	HHA COST CENTER (omit cents)	CLINICAL ENGINEER	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	
		6.01	7	8	9	10	11	
1	ADMINISTRATIVE AND GENERAL	1,061					1,760	1
2	SKILLED NURSING CARE							2
3	PHYSICAL THERAPY							3
4	OCCUPATIONAL THERAPY							4
5	SPEECH PATHOLOGY							5
6	MEDICAL SOCIAL SERVICES							6
7	HOME HEALTH AIDE							7
8	SUPPLIES							8
9	DRUGS							9
10	DME							10
11	HOME DIALYSIS AIDE SERVICES							11
12	RESPIRATORY THERAPY							12
13	PRIVATE DUTY NURSING							13
14	CLINIC							14
15	HEALTH PROMOTION ACTIVITIES							15
16	DAY CARE PROGRAM							16
17	HOME DELIVERED MEALS PROGRAM							17
18	HOMEMAKER SERVICE							18
19	ALL OTHERS							19
20	TOTALS (sum of lines 1-19)(2)	1,061					1,760	20
21	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

(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.



PALOS COMMUNITY HOSPITAL Provider CCN: 14-0062	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 08:45 Version: 2014.03
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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA CCN: 14-7470

WORKSHEET H-2
PART I

	HHA COST CENTER (omit cents)	MAIN- TENANCE OF PERSONNEL	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		12	13	14	15	16	17	
1	ADMINISTRATIVE AND GENERAL			121,037	4,343			1
2	SKILLED NURSING CARE							2
3	PHYSICAL THERAPY							3
4	OCCUPATIONAL THERAPY							4
5	SPEECH PATHOLOGY							5
6	MEDICAL SOCIAL SERVICES							6
7	HOME HEALTH AIDE							7
8	SUPPLIES							8
9	DRUGS							9
10	DME							10
11	HOME DIALYSIS AIDE SERVICES							11
12	RESPIRATORY THERAPY							12
13	PRIVATE DUTY NURSING							13
14	CLINIC							14
15	HEALTH PROMOTION ACTIVITIES							15
16	DAY CARE PROGRAM							16
17	HOME DELIVERED MEALS PROGRAM							17
18	HOMEMAKER SERVICE							18
19	ALL OTHERS							19
20	TOTALS (sum of lines 1-19)(2)			121,037	4,343			20
21	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

(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.



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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA CCN: 14-7470

WORKSHEET H-2
PART I

	HHA COST CENTER (omit cents)	NONPHYSIC. ANESTHET.	NURSING SCHOOL	I&R SALARY & FRINGES	I&R PROGRAM COSTS	PARAMED EDUCATION	SUBTOTAL (sum of col.4A-23)	
		19	20	21	22	23	24	
1	ADMINISTRATIVE AND GENERAL						3,217,877	1
2	SKILLED NURSING CARE						6,156,611	2
3	PHYSICAL THERAPY						2,652,883	3
4	OCCUPATIONAL THERAPY						465,114	4
5	SPEECH PATHOLOGY						170,960	5
6	MEDICAL SOCIAL SERVICES						134,007	6
7	HOME HEALTH AIDE						1,084,370	7
8	SUPPLIES						134,864	8
9	DRUGS						7,707	9
10	DME							10
11	HOME DIALYSIS AIDE SERVICES							11
12	RESPIRATORY THERAPY							12
13	PRIVATE DUTY NURSING							13
14	CLINIC							14
15	HEALTH PROMOTION ACTIVITIES							15
16	DAY CARE PROGRAM							16
17	HOME DELIVERED MEALS PROGRAM							17
18	HOMEMAKER SERVICE							18
19	ALL OTHERS							19
20	TOTALS (sum of lines 1-19)(2)						14,024,393	20
21	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

(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.



COMPU-MAX

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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

HHA CCN: 14-7470

WORKSHEET H-2
PART I

	HHA COST CENTER (omit cents)	I&R COST & POST STEP- DOWN ADJS	SUBTOTAL (sum of col.4A-23)	ALLOCATED HHA A&G (see Pt.2)	TOTAL HHA COSTS		
		25	26	27	28		
1	ADMINISTRATIVE AND GENERAL		3,217,877				1
2	SKILLED NURSING CARE		6,156,611	1,833,265	7,989,876		2
3	PHYSICAL THERAPY		2,652,883	789,954	3,442,837		3
4	OCCUPATIONAL THERAPY		465,114	138,498	603,612		4
5	SPEECH PATHOLOGY		170,960	50,907	221,867		5
6	MEDICAL SOCIAL SERVICES		134,007	39,904	173,911		6
7	HOME HEALTH AIDE		1,084,370	322,895	1,407,265		7
8	SUPPLIES		134,864	40,159	175,023		8
9	DRUGS		7,707	2,295	10,002		9
10	DME						10
11	HOME DIALYSIS AIDE SERVICES						11
12	RESPIRATORY THERAPY						12
13	PRIVATE DUTY NURSING						13
14	CLINIC						14
15	HEALTH PROMOTION ACTIVITIES						15
16	DAY CARE PROGRAM						16
17	HOME DELIVERED MEALS PROGRAM						17
18	HOMEMAKER SERVICE						18
19	ALL OTHERS						19
20	TOTALS (sum of lines 1-19)(2)		14,024,393	3,217,877	14,024,393		20
21	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.			0.297772			21

(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.



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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

HHA CCN: 14-7470

WORKSHEET H-2
PART II

	HHA COST CENTER	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VALUE	EMPLOYEE BENEFITS DEPARTMENT FTES	COMMUNICATIONS # OF PHONES	DATA PROCESSING TIME SPENT	PURCH & STORES # OF REQUISIT.	
		1	2	4	5.01	5.02	5.03	
1	ADMINISTRATIVE AND GENERAL	720	69,267	114	86	19	582	1
2	SKILLED NURSING CARE							2
3	PHYSICAL THERAPY							3
4	OCCUPATIONAL THERAPY							4
5	SPEECH PATHOLOGY							5
6	MEDICAL SOCIAL SERVICES							6
7	HOME HEALTH AIDE							7
8	SUPPLIES							8
9	DRUGS							9
10	DME							10
11	HOME DIALYSIS AIDE SERVICES							11
12	RESPIRATORY THERAPY							12
13	PRIVATE DUTY NURSING							13
14	CLINIC							14
15	HEALTH PROMOTION ACTIVITIES							15
16	DAY CARE PROGRAM							16
17	HOME DELIVERED MEALS PROGRAM							17
18	HOMEMAKER SERVICE							18
19	ALL OTHERS							19
19.50	TELEMEDICINE							19.50
20	TOTALS (sum of lines 1-19)	720	69,267	114	86	19	582	20
21	TOTAL COST TO BE ALLOCATED	6,761	68,961	2,545,265	38,092	104,145	16,161	21
22	UNIT COST MULTIPLIER	9.390278		22,326.885965		5,481.315789		22
22	UNIT COST MULTIPLIER		0.995582		442.930233		27.768041	22



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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

HHA CCN: 14-7470

WORKSHEET H-2
PART II

	HHA COST CENTER	ADMITTING INPATIENT REVENUES	CASHIERING INPATIENT REVENUES	RECON- CILIATION	ADMINIS- TRATIVE & GENERAL ACCUM COST	MAIN- TENANCE & REPAIRS SQUARE FEET	CLINICAL ENGINEER TIME SPENT		
		5.04	5.05	4A.06	5.06	6	6.01		
1	ADMINISTRATIVE AND GENERAL				2,779,385	720	6	1	
2	SKILLED NURSING CARE				5,558,460			2	
3	PHYSICAL THERAPY				2,395,140			3	
4	OCCUPATIONAL THERAPY				419,925			4	
5	SPEECH PATHOLOGY				154,350			5	
6	MEDICAL SOCIAL SERVICES				120,987			6	
7	HOME HEALTH AIDE				979,017			7	
8	SUPPLIES				121,761			8	
9	DRUGS				6,958			9	
10	DME							10	
11	HOME DIALYSIS AIDE SERVICES							11	
12	RESPIRATORY THERAPY							12	
13	PRIVATE DUTY NURSING							13	
14	CLINIC							14	
15	HEALTH PROMOTION ACTIVITIES							15	
16	DAY CARE PROGRAM							16	
17	HOME DELIVERED MEALS PROGRAM							17	
18	HOMEMAKER SERVICE							18	
19	ALL OTHERS							19	
19.50	TELEMEDICINE							19.50	
20	TOTALS (sum of lines 1-19)				12,535,983	720	6	20	
21	TOTAL COST TO BE ALLOCATED				1,349,010	11,199	1,061	21	
22	UNIT COST MULTIPLIER					15.554167		22	
22	UNIT COST MULTIPLIER				0.107611		176.833333	22	



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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

HHA CCN: 14-7470

WORKSHEET H-2
PART II

	HHA COST CENTER	OPERATION OF PLANT SQUARE FEET	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	HOUSE-KEEPING HOURS OF SERVICE	DIETARY MEALS SERVED	CAFETERIA FTES	MAINTENANCE OF PERSONNEL NUMBER HOUSED	
		7	8	9	10	11	12	
1	ADMINISTRATIVE AND GENERAL					2		1
2	SKILLED NURSING CARE							2
3	PHYSICAL THERAPY							3
4	OCCUPATIONAL THERAPY							4
5	SPEECH PATHOLOGY							5
6	MEDICAL SOCIAL SERVICES							6
7	HOME HEALTH AIDE							7
8	SUPPLIES							8
9	DRUGS							9
10	DME							10
11	HOME DIALYSIS AIDE SERVICES							11
12	RESPIRATORY THERAPY							12
13	PRIVATE DUTY NURSING							13
14	CLINIC							14
15	HEALTH PROMOTION ACTIVITIES							15
16	DAY CARE PROGRAM							16
17	HOME DELIVERED MEALS PROGRAM							17
18	HOMEMAKER SERVICE							18
19	ALL OTHERS							19
19.50	TELEMEDICINE							19.50
20	TOTALS (sum of lines 1-19)					2		20
21	TOTAL COST TO BE ALLOCATED					1,760		21
22	UNIT COST MULTIPLIER					880.000000		22
22	UNIT COST MULTIPLIER							22



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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

HHA CCN: 14-7470

WORKSHEET H-2
PART II

	HHA COST CENTER	NURSING ADMINIS- TRATION FTES	CENTRAL SERVICES & SUPPLY COSTED REQUIS.	PHARMACY COSTED REQUIS.	MEDICAL RECORDS & LIBRARY TIME SPENT	SOCIAL SERVICE TIME SPENT	NONPHYSIC. ANESTHET. ASSIGNED TIME	
		13	14	15	16	17	19	
1	ADMINISTRATIVE AND GENERAL		162,181	4,870				1
2	SKILLED NURSING CARE							2
3	PHYSICAL THERAPY							3
4	OCCUPATIONAL THERAPY							4
5	SPEECH PATHOLOGY							5
6	MEDICAL SOCIAL SERVICES							6
7	HOME HEALTH AIDE							7
8	SUPPLIES							8
9	DRUGS							9
10	DME							10
11	HOME DIALYSIS AIDE SERVICES							11
12	RESPIRATORY THERAPY							12
13	PRIVATE DUTY NURSING							13
14	CLINIC							14
15	HEALTH PROMOTION ACTIVITIES							15
16	DAY CARE PROGRAM							16
17	HOME DELIVERED MEALS PROGRAM							17
18	HOMEMAKER SERVICE							18
19	ALL OTHERS							19
19.50	TELEMEDICINE							19.50
20	TOTALS (sum of lines 1-19)		162,181	4,870				20
21	TOTAL COST TO BE ALLOCATED		121,037	4,343				21
22	UNIT COST MULTIPLIER			0.891786				22
22	UNIT COST MULTIPLIER		0.746308					22



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ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

HHA CCN: 14-7470

WORKSHEET H-2
PART II

	HHA COST CENTER	NURSING SCHOOL ASSIGNED TIME	I&R SALARY & FRINGES ASSIGNED TIME	I&R PROGRAM COSTS ASSIGNED TIME	PARAMED EDUCATION ASSIGNED TIME		
		20	21	22	23		
1	ADMINISTRATIVE AND GENERAL						1
2	SKILLED NURSING CARE						2
3	PHYSICAL THERAPY						3
4	OCCUPATIONAL THERAPY						4
5	SPEECH PATHOLOGY						5
6	MEDICAL SOCIAL SERVICES						6
7	HOME HEALTH AIDE						7
8	SUPPLIES						8
9	DRUGS						9
10	DME						10
11	HOME DIALYSIS AIDE SERVICES						11
12	RESPIRATORY THERAPY						12
13	PRIVATE DUTY NURSING						13
14	CLINIC						14
15	HEALTH PROMOTION ACTIVITIES						15
16	DAY CARE PROGRAM						16
17	HOME DELIVERED MEALS PROGRAM						17
18	HOMEMAKER SERVICE						18
19	ALL OTHERS						19
19.50	TELEMEDICINE						19.50
20	TOTALS (sum of lines 1-19)						20
21	TOTAL COST TO BE ALLOCATED						21
22	UNIT COST MULTIPLIER						22
22	UNIT COST MULTIPLIER						22



PALOS COMMUNITY HOSPITAL Provider CCN: 14-0062	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 08:45 Version: 2014.03
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APPORTIONMENT OF PATIENT SERVICE COSTS

HHA CCN: 14-7470

WORKSHEET H-3
PARTS I & II

CHECK APPLICABLE BOX: [] TITLE V [XX] TITLE XVIII [] TITLE XIX

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

COST PER VISIT COMPUTATION								
	PATIENT SERVICES	FROM WKST. H-2, PART I, COL. 28, LINE	FACILITY COSTS (from Wkst. H-2, Part I)	SHARED ANCILLARY COSTS (from Part II)	TOTAL HHA COSTS (cols. 1 + 2)	TOTAL VISITS	AVERAGE COST PER VISIT (col. 3 ÷ col. 4)	
			1	2	3	4	5	
1	SKILLED NURSING CARE	2	7,989,876		7,989,876	47,954	166.62	1
2	PHYSICAL THERAPY	3	3,442,837		3,442,837	21,647	159.04	2
3	OCCUPATIONAL THERAPY	4	603,612		603,612	3,399	177.59	3
4	SPEECH PATHOLOGY	5	221,867		221,867	886	250.41	4
5	MEDICAL SOCIAL SERVICES	6	173,911		173,911	670	259.57	5
6	HOME HEALTH AIDE	7	1,407,265		1,407,265	12,001	117.26	6
7	TOTAL (sum of lines 1-6)		13,839,368		13,839,368	86,557		7

LIMITATION COST COMPUTATION					PROGRAM VISITS		
					PART B		
	PATIENT SERVICES		CBSA NO.	PART A	NOT SUBJECT TO DEDUCTIBLES & COINSURANCE	SUBJECT TO DEDUCTIBLES & COINSURANCE	
			1	2	3	4	
8	SKILLED NURSING CARE		16974	18,623	20,625		8
9	PHYSICAL THERAPY		16974	8,788	8,192		9
10	OCCUPATIONAL THERAPY		16974	1,465	1,471		10
11	SPEECH PATHOLOGY		16974	431	342		11
12	MEDICAL SOCIAL SERVICES		16974	246	338		12
13	HOME HEALTH AIDE		16974	3,455	7,072		13
14	TOTAL (sum of lines 8-13)			33,008	38,040		14

SUPPLIES AND DRUGS COSTS COMPUTATIONS								
	OTHER PATIENT SERVICES	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)	RATIO (col. 3 ÷ col. 4)	
			1	2	3	4	5	
15	COST OF MEDICAL SUPPLIES	8	175,023		175,023	281,135	0.622559	15
16	COST OF DRUGS	9	10,002		10,002	1,395	7.169892	16

PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS

		FROM WKST. C. PART I, COL. 9, LINE	COST TO CHARGE RATIO	TOTAL HHA CHARGES (from provider records)	HHA SHARED ANCILLARY COSTS (col. 1 x col. 2)	TRANSFER TO PART I AS INDICATED	
			1	2	3	4	
1	PHYSICAL THERAPY	66	0.347987			col. 2, line 2	1
2	OCCUPATIONAL THERAPY	67				col. 2, line 3	2
3	SPEECH PATHOLOGY	68	0.206348			col. 2, line 4	3
4	MEDICAL SUPPLIES CHARGED TO PAT	71	0.198522			col. 2, line 15	4
5	DRUGS CHARGED TO PATIENTS	73	0.333952			col. 2, line 16	5



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APPORTIONMENT OF PATIENT SERVICE COSTS

HHA CCN: 14-7470

WORKSHEET H-3
PARTS I & II

CHECK APPLICABLE BOX: [] TITLE V [XX] TITLE XVIII [] TITLE XIX

PART I - COMPUTATION OF THE AGGREGATE PROGRAM COST

COST PER VISIT COMPUTATION		PROGRAM VISITS			COST OF SERVICES				
		PART B			PART B				
	PATIENT SERVICES	PART A	NOT SUBJECT TO DEDUCTIBLES & COINSURANCE	SUBJECT TO DEDUCTIBLES & COINSURANCE	PART A	NOT SUBJECT TO DEDUCTIBLES & COINSURANCE	SUBJECT TO DEDUCTIBLES & COINSURANCE	TOTAL PROGRAM COST (sum of cols 9-10)	
		6	7	8	9	10	11	12	
1	SKILLED NURSING CARE	18,623	20,625		3,102,964	3,436,538		6,539,502	1
2	PHYSICAL THERAPY	8,788	8,192		1,397,644	1,302,856		2,700,500	2
3	OCCUPATIONAL THERAPY	1,465	1,471		260,169	261,235		521,404	3
4	SPEECH PATHOLOGY	431	342		107,927	85,640		193,567	4
5	MEDICAL SOCIAL SERVICES	246	338		63,854	87,735		151,589	5
6	HOME HEALTH AIDE	3,455	7,072		405,133	829,263		1,234,396	6
7	TOTAL (sum of lines 1-6)	33,008	38,040		5,337,691	6,003,267		11,340,958	7

SUPPLIES AND DRUGS COSTS COMPUTATIONS		PROGRAM COVERED CHARGES			COST OF SERVICES				
		PART B			PART B				
	OTHER PATIENT SERVICES	PART A	NOT SUBJECT TO DEDUCTIBLES & COINSURANCE	SUBJECT TO DEDUCTIBLES & COINSURANCE	PART A	NOT SUBJECT TO DEDUCTIBLES & COINSURANCE	SUBJECT TO DEDUCTIBLES & COINSURANCE		
		6	7	8	9	10	11		
15	COST OF MEDICAL SUPPLIES								15
16	COST OF DRUGS		1,395			10,002			16



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CALCULATION OF HHA REIMBURSEMENT SETTLEMENT

HHA CCN: 14-7470

WORKSHEET H-4
PARTS I & II

CHECK APPLICABLE BOX: [] TITLE V [XX] TITLE XVIII [] TITLE XIX

PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES

	DESCRIPTION	PART A 1	PART B		
			NOT SUBJECT TO DEDUCTIBLES & COINSURANCE 2	SUBJECT TO DEDUCTIBLES & COINSURANCE 3	
	REASONABLE COST OF PART A & PART B SERVICES				
1	REASONABLE COST OF SERVICES (see instructions)		10,002		1
2	TOTAL CHARGES		1,395		2
	CUSTOMARY CHARGES				
3	AMOUNT ACTUALLY COLLECTED FROM PATIENTS LIABLE FOR PAYMENT FOR SERVICES ON A CHARGE BASIS (from your records)				3
4	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)				4
5	RATIO OF LINE 3 TO LINE 4 (not to exceed 1.000000)				5
6	TOTAL CUSTOMARY CHARGES (see instructions)		1,395		6
7	EXCESS OF TOTAL CUSTOMARY CHARGES OVER TOTAL REASONABLE COST (complete only if line 6 exceeds line 1)				7
8	EXCESS OF REASONABLE COST OVER CUSTOMARY CHARGES (complete only if line 1 exceeds line 6)		8,607		8
9	PRIMARY PAYER PAYMENTS		4,678		9

COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT

	DESCRIPTION	PART A SERVICES	PART B SERVICES	
		1	2	
10	TOTAL REASONABLE COST (see instructions)		5,324	10
11	TOTAL PPS REIMBURSEMENT - FULL EPISODES WITHOUT OUTLIERS	4,720,205	4,974,755	11
12	TOTAL PPS REIMBURSEMENT - FULL EPISODES WITH OUTLIERS	182,796	315,333	12
13	TOTAL PPS REIMBURSEMENT - LUPA EPISODES	60,924	93,046	13
14	TOTAL PPS REIMBURSEMENT - PEP EPISODES	41,236	50,895	14
15	TOTAL PPS OUTLIER REIMBURSEMENT - FULL EPISODES WITH OUTLIERS	41,589	69,329	15
16	TOTAL PPS OUTLIER REIMBURSEMENT - PEP EPISODES	484	2,152	16
17	TOTAL OTHER PAYMENTS			17
18	DME PAYMENTS			18
19	OXYGEN PAYMENTS			19
20	PROSTHETIC AND ORTHOTIC PAYMENTS			20
21	PART B DEDUCTIBLES BILLED TO MEDICARE PATIENTS (exclude coinsurance)			21
22	SUBTOTAL (sum of lines 10-20 minus line 21)	5,047,234	5,510,834	22
23	EXCESS REASONABLE COST (from line 8)		8,607	23
24	SUBTOTAL (line 22 minus line 23)	5,047,234	5,502,227	24
25	COINSURANCE BILLED TO PROGRAM PATIENTS (from your records)			25
26	NET COST (line 24 minus line 25)	5,047,234	5,502,227	26
27	REIMBURSABLE BAD DEBTS (from your records)			27
28	REIMBURSABLE BAD DEBTS FOR DUAL ELIGIBLE BENEFICIARIES (see instructions)			28
29	TOTAL COSTS - CURRENT COST REPORTING PERIOD (line 26 plus line 27)	5,047,234	5,502,227	29
30	OTHER ADJUSTMENTS (SPECIFY) (see instructions)			30
31	SUBTOTAL (line 29 plus/minus line 30)	5,047,234	5,502,227	31
31.01	SEQUESTRATION ADJUSTMENT (see instructions)	69,663	84,639	31.01
32	INTERIM PAYMENTS (see instructions)	4,977,571	5,417,588	32
33	TENTATIVE SETTLEMENT (for contractor use only)			33
34	BALANCE DUE PROVIDER/PROGRAM (line 31 minus lines 31.01, 32 and 33)			34
35	PROTESTED AMOUNTS (nonallowable cost report items) IN ACCORDANCE WITH CMS PUB 15-2, SECTION 115-2			35



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ANALYSIS OF PAYMENTS TO PROVIDER-BASED HHAs FOR SERVICES RENDERED TO PROGRAM BENEFICIARIES HHA CCN: 14-7470

WORKSHEET H-5

			PART A		PART B		
DESCRIPTION			mm/dd/yyyy	AMOUNT	mm/dd/yyyy	AMOUNT	
			1	2	3	4	
1	TOTAL INTERIM PAYMENTS PAID TO PROVIDER			4,977,571		5,416,220	1
2	INTERIM PAYMENTS PAYABLE ON INDIVIDUAL BILLS, EITHER SUBMITTED OR TO BE SUBMITTED TO THE INTERMEDIARY FOR SERVICES RENDERED IN THE COST REPORTING PERIOD. IF NONE, WRITE 'NONE' OR ENTER A ZERO					1,368	2
3	LIST SEPARATELY EACH RETROACTIVE LUMP SUM ADJUSTMENT		.01				3.01
	AMOUNT BASED ON SUBSEQUENT REVISION OF THE INTERIM		.02				3.02
	RATE FOR THE COST REPORTING PERIOD. ALSO SHOW DATE OF EACH PAYMENT. IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	PROGRAM	.03				3.03
		TO	.04				3.04
		PROVIDER	.05				3.05
			.06				3.06
			.07				3.07
			.08				3.08
			.09				3.09
			.10				3.10
			.50				3.50
			.51				3.51
		PROVIDER	.52				3.52
		TO	.53				3.53
		PROGRAM	.54				3.54
			.55				3.55
			.56				3.56
			.57				3.57
			.58				3.58
			.59				3.59
	SUBTOTAL (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		.99				3.99
4	TOTAL INTERIM PAYMENTS (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)			4,977,571		5,417,588	4
TO BE COMPLETED BY CONTRACTOR							
5	LIST SEPARATELY EACH TENTATIVE SETTLEMENT PAYMENT		.01				5.01
	AFTER DESK REVIEW. ALSO SHOW DATE OF EACH PAYMENT.		.02				5.02
	IF NONE, WRITE 'NONE' OR ENTER A ZERO. (1)	PROGRAM	.03				5.03
		TO	.04				5.04
		PROVIDER	.05				5.05
			.06				5.06
			.07				5.07
			.08				5.08
			.09				5.09
			.10				5.10
			.50				5.50
			.51				5.51
		PROVIDER	.52				5.52
		TO	.53				5.53
		PROGRAM	.54				5.54
			.55				5.55
			.56				5.56
			.57				5.57
			.58				5.58
			.59				5.59
	SUBTOTAL (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		.99				5.99
6	DETERMINED NET SETTLEMENT AMOUNT (balance due) BASED ON THE COST REPORT (1)		.01	69,663		84,639	6.01
			.02				6.02
7	TOTAL MEDICARE PROGRAM LIABILITY (see instructions)			5,047,234		5,502,227	7
8	NAME OF CONTRACTOR			CONTRACTOR NUMBER		NPR DATE (Month/Day/Year)	8

(1) On lines 3, 5, and 6, where an amount is due provider to program, show the amount and date on which the provider agrees to the amount of repayment even though total repayment is not accomplished until a later date.



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ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

HOSPICE CCN: 14-1591

WORKSHEET K

	COST CENTER DESCRIPTIONS	SALARIES (from Wkst. K-1)	EMPLOYEE BENEFITS (from Wkst. K-2)	TRANSPOR- TATION (see inst.)	CONTRACTED SERVICES (from Wkst. K-3)	OTHER	
		1	2	3	4	5	
	GENERAL SERVICE COST CENTER						
1	CAPITAL RELATED COSTS-BLDG AND FIXT.						1
2	CAPITAL RELATED COSTS-MOVABLE EQUIP.						2
3	PLANT OPERATION AND MAINTENANCE						3
4	TRANSPORTATION - STAFF					99,937	4
5	VOLUNTEER SERVICE COORDINATION	69,333					5
6	ADMINISTRATIVE AND GENERAL	324,178				689,546	6
	INPATIENT CARE SERVICE						
7	INPATIENT - GENERAL CARE						7
8	INPATIENT - RESPITE CARE						8
	VISITING SERVICES						
9	PHYSICIAN SERVICES					50,057	9
10	NURSING CARE	1,510,769					10
11	NURSING CARE-CONTINUOUS HOME CARE						11
12	PHYSICAL THERAPY	75,697					12
13	OCCUPATIONAL THERAPY						13
14	SPEECH/LANGUAGE PATHOLOGY				380		14
15	MEDICAL SOCIAL SERVICES	199,448					15
16	SPIRITUAL COUNSELING	37,680					16
17	DIETARY COUNSELING	14,231					17
18	COUNSELING - OTHER						18
19	HOME HEALTH AIDE AND HOME MAKER	243,163					19
20	HH AIDE & HOME MAKER - CONT. HOME CARE						20
21	OTHER						21
	OTHER HOSPICE SERVICE COSTS						
22	DRUGS, BIOLOGICAL AND INFUSION THERAPY					355,195	22
23	ANALGESICS						23
24	SEDATIVES/HYPNOTICS						24
25	OTHER - SPECIFY						25
26	DURABLE MEDICAL EQUIPMENT/OXYGEN						26
27	PATIENT TRANSPORTATION						27
28	IMAGING SERVICES						28
29	LABS AND DIAGNOSTICS						29
30	MEDICAL SUPPLIES					7,782	30
31	OUTPATIENT SERVICES (including E/R Dept.)						31
32	RADIATION THERAPY						32
33	CHEMOTHERAPY						33
34	OTHER						34
	HOSPICE NONREIMBURSABLE SERVICE						
35	BEREAVEMENT PROGRAM COSTS	41,036					35
36	VOLUNTEER PROGRAM COSTS						36
37	FUNDRAISING						37
38	OTHER PROGRAM COSTS						38
39	TOTAL (sum of lines 1-38)	2,515,535			380	1,202,517	39



COMPU-MAX

PALOS COMMUNITY HOSPITAL Provider CCN: 14-0062	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 08:45 Version: 2014.03
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ANALYSIS OF PROVIDER-BASED HOSPICE COSTS

HOSPICE CCN: 14-1591

WORKSHEET K

	TOTAL (cols. 1-5) 6	RECLASSI- FICATION 7	SUBTOTAL (col. 6 ± col. 7) 8	ADJUST- MENTS 9	TOTAL (col. 8 ± col. 9) 10	
GENERAL SERVICE COST CENTER						
1 CAPITAL RELATED COSTS-BLDG AND FIXT.						1
2 CAPITAL RELATED COSTS-MOVABLE EQUIP.						2
3 PLANT OPERATION AND MAINTENANCE						3
4 TRANSPORTATION - STAFF	99,937		99,937		99,937	4
5 VOLUNTEER SERVICE COORDINATION	69,333		69,333		69,333	5
6 ADMINISTRATIVE AND GENERAL	1,013,724	2,223	1,015,947	-189	1,015,758	6
INPATIENT CARE SERVICE						
7 INPATIENT - GENERAL CARE						7
8 INPATIENT - RESPITE CARE						8
VISITING SERVICES						
9 PHYSICIAN SERVICES	50,057		50,057		50,057	9
10 NURSING CARE	1,510,769		1,510,769		1,510,769	10
11 NURSING CARE-CONTINUOUS HOME CARE						11
12 PHYSICAL THERAPY	75,697		75,697		75,697	12
13 OCCUPATIONAL THERAPY						13
14 SPEECH/LANGUAGE PATHOLOGY	380		380		380	14
15 MEDICAL SOCIAL SERVICES	199,448		199,448		199,448	15
16 SPIRITUAL COUNSELING	37,680		37,680		37,680	16
17 DIETARY COUNSELING	14,231		14,231		14,231	17
18 COUNSELING - OTHER						18
19 HOME HEALTH AIDE AND HOMEMAKER	243,163		243,163		243,163	19
20 HH AIDE & HOMEMAKER - CONT. HOME CARE						20
21 OTHER						21
OTHER HOSPICE SERVICE COSTS						
22 DRUGS, BIOLOGICAL AND INFUSION THERAPY	355,195		355,195		355,195	22
23 ANALGESICS						23
24 SEDATIVES/HYPNOTICS						24
25 OTHER - SPECIFY						25
26 DURABLE MEDICAL EQUIPMENT/OXYGEN						26
27 PATIENT TRANSPORTATION						27
28 IMAGING SERVICES						28
29 LABS AND DIAGNOSTICS						29
30 MEDICAL SUPPLIES	7,782		7,782		7,782	30
31 OUTPATIENT SERVICES (including E/R Dept.)						31
32 RADIATION THERAPY						32
33 CHEMOTHERAPY						33
34 OTHER						34
HOSPICE NONREIMBURSABLE SERVICE						
35 BEREAVEMENT PROGRAM COSTS	41,036		41,036		41,036	35
36 VOLUNTEER PROGRAM COSTS						36
37 FUNDRAISING						37
38 OTHER PROGRAM COSTS						38
39 TOTAL (sum of lines 1-38)	3,718,432	4,446	3,720,655	-378	3,720,466	39



PALOS COMMUNITY HOSPITAL Provider CCN: 14-0062	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 08:45 Version: 2014.03
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HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

HOSPICE CCN: 14-1591

WORKSHEET K-1

	COST CENTER DESCRIPTIONS (omit cents)	ADMINIS- TRATOR	DIRECTOR	MEDICAL SOCIAL WORKERS	SUPERVISORS	NURSES	
		1	2	3	4	5	
	GENERAL SERVICE COST CENTER						
1	CAPITAL RELATED COSTS-BLDG AND FIX						1
2	CAPITAL RELATED COSTS-MOVABLE EQUI						2
3	PLANT OPERATION AND MAINTENANCE						3
4	TRANSPORTATION - STAFF						4
5	VOLUNTEER SERVICE COORDINATION						5
6	ADMINISTRATIVE AND GENERAL		28,079		8,771		6
	INPATIENT CARE SERVICE						
7	INPATIENT - GENERAL CARE						7
8	INPATIENT - RESPITE CARE						8
	VISITING SERVICES						
9	PHYSICIAN SERVICES						9
10	NURSING CARE				258,013	1,252,756	10
11	NURSING CARE-CONTINUOUS HOME CARE						11
12	PHYSICAL THERAPY						12
13	OCCUPATIONAL THERAPY						13
14	SPEECH/LANGUAGE PATHOLOGY						14
15	MEDICAL SOCIAL SERVICES						15
16	SPIRITUAL COUNSELING						16
17	DIETARY COUNSELING						17
18	COUNSELING - OTHER						18
19	HOME HEALTH AIDE AND HOMEMAKER						19
20	HH AIDE & HOMEMAKER - CONT. HOME C						20
21	OTHER						21
	OTHER HOSPICE SERVICE COSTS						
22	DRUGS, BIOLOGICAL AND INFUSION THE						22
23	ANALGESICS						23
24	SEDATIVES/HYPNOTICS						24
25	OTHER - SPECIFY						25
26	DURABLE MEDICAL EQUIPMENT/OXYGEN						26
27	PATIENT TRANSPORTATION						27
28	IMAGING SERVICES						28
29	LABS AND DIAGNOSTICS						29
30	MEDICAL SUPPLIES						30
31	OUTPATIENT SERVICES (including E/R						31
32	RADIATION THERAPY						32
33	CHEMOTHERAPY						33
34	OTHER						34
	HOSPICE NONREIMBURSABLE SERVICE						
35	BEREAVEMENT PROGRAM COSTS						35
36	VOLUNTEER PROGRAM COSTS						36
37	FUNDRAISING						37
38	OTHER PROGRAM COSTS						38
39	TOTAL (sum of lines 1-38)		28,079		266,784	1,252,756	39

(1) Transfer the amount in column 9 to Wkst. K, column 1.



PALOS COMMUNITY HOSPITAL Provider CCN: 14-0062	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 08:45 Version: 2014.03
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HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGES

HOSPICE CCN: 14-1591

WORKSHEET K-1

	TOTAL THERAPISTS	AIDES	ALL OTHER	TOTAL (1)	
	6	7	8	9	
GENERAL SERVICE COST CENTER					
1					1
2					2
3					3
4					4
5			69,333	69,333	5
6			287,328	324,178	6
INPATIENT CARE SERVICE					
7					7
8					8
VISITING SERVICES					
9					9
10				1,510,769	10
11					11
12	75,697			75,697	12
13					13
14					14
15			199,448	199,448	15
16			37,680	37,680	16
17			14,231	14,231	17
18					18
19			243,163	243,163	19
20					20
21					21
OTHER HOSPICE SERVICE COSTS					
22					22
23					23
24					24
25					25
26					26
27					27
28					28
29					29
30					30
31					31
32					32
33					33
34					34
HOSPICE NONREIMBURSABLE SERVICE					
35			41,036	41,036	35
36					36
37					37
38					38
39	75,697		892,219	2,515,535	39

(1) Transfer the amount in column 9 to Wkst. K, column 1.



PALOS COMMUNITY HOSPITAL Provider CCN: 14-0062	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 08:45 Version: 2014.03
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HOSPICE COMPENSATION ANALYSIS EMPLOYEE BENEFITS (PAYROLL RELATED)

HOSPICE CCN: 14-1591

WORKSHEET K-2

	COST CENTER DESCRIPTIONS (omit cents)	ADMINIS- TRATOR	DIRECTOR	MEDICAL SOCIAL WORKERS	SUPERVISORS	NURSES	
		1	2	3	4	5	
	GENERAL SERVICE COST CENTER						
1	CAPITAL RELATED COSTS-BLDG AND FIX						1
2	CAPITAL RELATED COSTS-MOVABLE EQUI						2
3	PLANT OPERATION AND MAINTENANCE						3
4	TRANSPORTATION - STAFF						4
5	VOLUNTEER SERVICE COORDINATION						5
6	ADMINISTRATIVE AND GENERAL						6
	INPATIENT CARE SERVICE						
7	INPATIENT - GENERAL CARE						7
8	INPATIENT - RESPITE CARE						8
	VISITING SERVICES						
9	PHYSICIAN SERVICES						9
10	NURSING CARE						10
11	NURSING CARE-CONTINUOUS HOME CARE						11
12	PHYSICAL THERAPY						12
13	OCCUPATIONAL THERAPY						13
14	SPEECH/LANGUAGE PATHOLOGY						14
15	MEDICAL SOCIAL SERVICES						15
16	SPIRITUAL COUNSELING						16
17	DIETARY COUNSELING						17
18	COUNSELING - OTHER						18
19	HOME HEALTH AIDE AND HOMEMAKER						19
20	HH AIDE & HOMEMAKER - CONT. HOME C						20
21	OTHER						21
	OTHER HOSPICE SERVICE COSTS						
22	DRUGS, BIOLOGICAL AND INFUSION THE						22
23	ANALGESICS						23
24	SEDATIVES/HYPNOTICS						24
25	OTHER - SPECIFY						25
26	DURABLE MEDICAL EQUIPMENT/OXYGEN						26
27	PATIENT TRANSPORTATION						27
28	IMAGING SERVICES						28
29	LABS AND DIAGNOSTICS						29
30	MEDICAL SUPPLIES						30
31	OUTPATIENT SERVICES (including E/R						31
32	RADIATION THERAPY						32
33	CHEMOTHERAPY						33
34	OTHER						34
	HOSPICE NONREIMBURSABLE SERVICE						
35	BEREAVEMENT PROGRAM COSTS						35
36	VOLUNTEER PROGRAM COSTS						36
37	FUNDRAISING						37
38	OTHER PROGRAM COSTS						38
39	TOTAL (sum of lines 1-38)						39

(1) Transfer the amount in column 9 to Wkst. K, column 2.



COMPU-MAX

PALOS COMMUNITY HOSPITAL Provider CCN: 14-0062	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 08:45 Version: 2014.03
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HOSPICE COMPENSATION ANALYSIS EMPLOYEE BENEFITS (PAYROLL RELATED)

HOSPICE CCN: 14-1591

WORKSHEET K-2

	TOTAL THERAPISTS	AIDES	ALL OTHER	TOTAL (1)	
	6	7	8	9	
GENERAL SERVICE COST CENTER					
1					1
2					2
3					3
4					4
5					5
6					6
INPATIENT CARE SERVICE					
7					7
8					8
VISITING SERVICES					
9					9
10					10
11					11
12					12
13					13
14					14
15					15
16					16
17					17
18					18
19					19
20					20
21					21
OTHER HOSPICE SERVICE COSTS					
22					22
23					23
24					24
25					25
26					26
27					27
28					28
29					29
30					30
31					31
32					32
33					33
34					34
HOSPICE NONREIMBURSABLE SERVICE					
35					35
36					36
37					37
38					38
39					39

(1) Transfer the amount in column 9 to Wkst. K, column 2.



PALOS COMMUNITY HOSPITAL Provider CCN: 14-0062	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 08:45 Version: 2014.03
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HOSPICE COMPENSATION ANALYSIS CONTRACTED SERVICES/PURCHASED SERVICES

HOSPICE CCN: 14-1591

WORKSHEET K-3

	COST CENTER DESCRIPTIONS (omit cents)	ADMINIS- TRATOR	DIRECTOR	MEDICAL SOCIAL WORKERS	SUPERVISORS	NURSES	
		1	2	3	4	5	
	GENERAL SERVICE COST CENTER						
1	CAPITAL RELATED COSTS-BLDG AND FIX						1
2	CAPITAL RELATED COSTS-MOVABLE EQUI						2
3	PLANT OPERATION AND MAINTENANCE						3
4	TRANSPORTATION - STAFF						4
5	VOLUNTEER SERVICE COORDINATION						5
6	ADMINISTRATIVE AND GENERAL						6
	INPATIENT CARE SERVICE						
7	INPATIENT - GENERAL CARE						7
8	INPATIENT - RESPITE CARE						8
	VISITING SERVICES						
9	PHYSICIAN SERVICES						9
10	NURSING CARE						10
11	NURSING CARE-CONTINUOUS HOME CARE						11
12	PHYSICAL THERAPY						12
13	OCCUPATIONAL THERAPY						13
14	SPEECH/LANGUAGE PATHOLOGY						14
15	MEDICAL SOCIAL SERVICES						15
16	SPIRITUAL COUNSELING						16
17	DIETARY COUNSELING						17
18	COUNSELING - OTHER						18
19	HOME HEALTH AIDE AND HOMEMAKER						19
20	HH AIDE & HOMEMAKER - CONT. HOME C						20
21	OTHER						21
	OTHER HOSPICE SERVICE COSTS						
22	DRUGS, BIOLOGICAL AND INFUSION THE						22
23	ANALGESICS						23
24	SEDATIVES/HYPNOTICS						24
25	OTHER - SPECIFY						25
26	DURABLE MEDICAL EQUIPMENT/OXYGEN						26
27	PATIENT TRANSPORTATION						27
28	IMAGING SERVICES						28
29	LABS AND DIAGNOSTICS						29
30	MEDICAL SUPPLIES						30
31	OUTPATIENT SERVICES (including E/R						31
32	RADIATION THERAPY						32
33	CHEMOTHERAPY						33
34	OTHER						34
	HOSPICE NONREIMBURSABLE SERVICE						
35	BEREAVEMENT PROGRAM COSTS						35
36	VOLUNTEER PROGRAM COSTS						36
37	FUNDRAISING						37
38	OTHER PROGRAM COSTS						38
39	TOTAL (sum of lines 1-38)						39

(1) Transfer the amount in column 9 to Wkst. K, column 4.



COMPU-MAX

PALOS COMMUNITY HOSPITAL Provider CCN: 14-0062	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 08:45 Version: 2014.03
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HOSPICE COMPENSATION ANALYSIS CONTRACTED SERVICES/PURCHASED SERVICES

HOSPICE CCN: 14-1591

WORKSHEET K-3

	TOTAL THERAPISTS	AIDES	ALL OTHER	TOTAL (1)	
	6	7	8	9	
GENERAL SERVICE COST CENTER					
1					1
2					2
3					3
4					4
5					5
6					6
INPATIENT CARE SERVICE					
7					7
8					8
VISITING SERVICES					
9					9
10					10
11					11
12					12
13					13
14	380			380	14
15					15
16					16
17					17
18					18
19					19
20					20
21					21
OTHER HOSPICE SERVICE COSTS					
22					22
23					23
24					24
25					25
26					26
27					27
28					28
29					29
30					30
31					31
32					32
33					33
34					34
HOSPICE NONREIMBURSABLE SERVICE					
35					35
36					36
37					37
38					38
39	380			380	39

(1) Transfer the amount in column 9 to Wkst. K, column 4.



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PALOS COMMUNITY HOSPITAL Provider CCN: 14-0062	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 08:45 Version: 2014.03
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COST ALLOCATION - HOSPICE GENERAL SERVICE COST

HOSPICE CCN: 14-1591

WORKSHEET K-4
PART I

	COST CENTER DESCRIPTIONS	CAPITAL RELATED COSTS				
		NET EXPENSES FOR COST ALLOCATION	BUILDINGS & FIXTURES	MOVABLE EQUIPMENT	PLANT OPERATION & MAINT.	
		0	1	2	3	4
	GENERAL SERVICE COST CENTER					
1	CAPITAL RELATED COSTS-BLDG AND FIX					1
2	CAPITAL RELATED COSTS-MOVABLE EQUI					2
3	PLANT OPERATION AND MAINTENANCE					3
4	TRANSPORTATION - STAFF	99,937				99,937
5	VOLUNTEER SERVICE COORDINATION	69,333				5
6	ADMINISTRATIVE AND GENERAL	1,015,758				99,937
	INPATIENT CARE SERVICE					
7	INPATIENT - GENERAL CARE					7
8	INPATIENT - RESPITE CARE					8
	VISITING SERVICES					
9	PHYSICIAN SERVICES	50,057				9
10	NURSING CARE	1,510,769				10
11	NURSING CARE-CONTINUOUS HOME CARE					11
12	PHYSICAL THERAPY	75,697				12
13	OCCUPATIONAL THERAPY					13
14	SPEECH/LANGUAGE PATHOLOGY	380				14
15	MEDICAL SOCIAL SERVICES	199,448				15
16	SPIRITUAL COUNSELING	37,680				16
17	DIETARY COUNSELING	14,231				17
18	COUNSELING - OTHER					18
19	HOME HEALTH AIDE AND HOMEMAKER	243,163				19
20	HH AIDE & HOMEMAKER - CONT. HOME C					20
21	OTHER					21
	OTHER HOSPICE SERVICE COSTS					
22	DRUGS, BIOLOGICAL AND INFUSION THE	355,195				22
23	ANALGESICS					23
24	SEDATIVES/HYPNOTICS					24
25	OTHER - SPECIFY					25
26	DURABLE MEDICAL EQUIPMENT/OXYGEN					26
27	PATIENT TRANSPORTATION					27
28	IMAGING SERVICES					28
29	LABS AND DIAGNOSTICS					29
30	MEDICAL SUPPLIES	7,782				30
31	OUTPATIENT SERVICES (including E/R					31
32	RADIATION THERAPY					32
33	CHEMOTHERAPY					33
34	OTHER					34
	HOSPICE NONREIMBURSABLE SERVICE					
35	BEREAVEMENT PROGRAM COSTS	41,036				35
36	VOLUNTEER PROGRAM COSTS					36
37	FUNDRAISING					37
38	OTHER PROGRAM COSTS					38
39	TOTAL (sum of lines 1-38)	3,720,466				99,937



COMPU-MAX

PALOS COMMUNITY HOSPITAL Provider CCN: 14-0062	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 08:45 Version: 2014.03
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COST ALLOCATION - HOSPICE GENERAL SERVICE COST

HOSPICE CCN: 14-1591

WORKSHEET K-4
PART I

	VOLUNTEER SERVICES COORDINATOR	SUBTOTAL (cols. 0 - 5)	ADMINISTRATIVE & GENERAL	TOTAL (col. 5 ± col. 6)	
	5	5A	6	7	
GENERAL SERVICE COST CENTER					
1					1
2					2
3					3
4					4
5	69,333				5
6	69,333	1,185,028	1,185,028		6
INPATIENT CARE SERVICE					
7					7
8					8
VISITING SERVICES					
9		50,057	23,396	73,453	9
10		1,510,769	706,112	2,216,881	10
11					11
12		75,697	35,380	111,077	12
13					13
14		380	178	558	14
15		199,448	93,219	292,667	15
16		37,680	17,611	55,291	16
17		14,231	6,651	20,882	17
18					18
19		243,163	113,651	356,814	19
20					20
21					21
OTHER HOSPICE SERVICE COSTS					
22		355,195	166,013	521,208	22
23					23
24					24
25					25
26					26
27					27
28					28
29					29
30		7,782	3,637	11,419	30
31					31
32					32
33					33
34					34
HOSPICE NONREIMBURSABLE SERVICE					
35		41,036	19,180	60,216	35
36					36
37					37
38					38
39	69,333	3,720,466		3,720,466	39



COMPU-MAX

PALOS COMMUNITY HOSPITAL Provider CCN: 14-0062	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 08:45 Version: 2014.03
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COST ALLOCATION - HOSPICE STATISTICAL BASIS

HOSPICE CCN: 14-1591

WORKSHEET K-4
PART II

	COST CENTER DESCRIPTIONS	CAPITAL RELATED COSTS				VOLUNTEER SERVICES COORDINATOR (Hours)	RECONCILIATION	ADMINISTRATIVE & GENERAL (Acc. Cost)	
		BUILDINGS & FIXTURES (Sq. Ft.)	MOVABLE EQUIPMENT (\$ Value)	PLANT OPERATION & MAINT. (Sq. Ft.)	TRANSPORTATION (Mileage)				
		1	2	3	4	5	6A	6	
	GENERAL SERVICE COST CENTER								
1	CAPITAL RELATED COSTS-BLDG AND FIX								1
2	CAPITAL RELATED COSTS-MOVABLE EQUI								2
3	PLANT OPERATION AND MAINTENANCE								3
4	TRANSPORTATION - STAFF				100				4
5	VOLUNTEER SERVICE COORDINATION					100			5
6	ADMINISTRATIVE AND GENERAL				100	100	-1,185,028	2,535,438	6
	INPATIENT CARE SERVICE								
7	INPATIENT - GENERAL CARE								7
8	INPATIENT - RESPITE CARE								8
	VISITING SERVICES								
9	PHYSICIAN SERVICES							50,057	9
10	NURSING CARE							1,510,769	10
11	NURSING CARE-CONTINUOUS HOME CARE								11
12	PHYSICAL THERAPY							75,697	12
13	OCCUPATIONAL THERAPY								13
14	SPEECH/LANGUAGE PATHOLOGY							380	14
15	MEDICAL SOCIAL SERVICES							199,448	15
16	SPIRITUAL COUNSELING							37,680	16
17	DIETARY COUNSELING							14,231	17
18	COUNSELING - OTHER								18
19	HOME HEALTH AIDE AND HOMEMAKER							243,163	19
20	HH AIDE & HOMEMAKER - CONT. HOME C								20
21	OTHER								21
	OTHER HOSPICE SERVICE COSTS								
22	DRUGS, BIOLOGICAL AND INFUSION THE							355,195	22
23	ANALGESICS								23
24	SEDATIVES/HYPNOTICS								24
25	OTHER - SPECIFY								25
26	DURABLE MEDICAL EQUIPMENT/OXYGEN								26
27	PATIENT TRANSPORTATION								27
28	IMAGING SERVICES								28
29	LABS AND DIAGNOSTICS								29
30	MEDICAL SUPPLIES							7,782	30
31	OUTPATIENT SERVICES (including E/R								31
32	RADIATION THERAPY								32
33	CHEMOTHERAPY								33
34	OTHER								34
	HOSPICE NONREIMBURSABLE SERVICE								
35	BEREAVEMENT PROGRAM COSTS							41,036	35
36	VOLUNTEER PROGRAM COSTS								36
37	FUNDRAISING								37
38	OTHER PROGRAM COSTS								38
39	TOTAL (sum of lines 1-38)				99,937	69,333		1,185,028	39
40	UNIT COST MULTIPLIER				999.370000	693.330000		0.467386	40



PALOS COMMUNITY HOSPITAL Provider CCN: 14-0062	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 08:45 Version: 2014.03
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ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

HOSPICE CCN: 14-1591

WORKSHEET K-5
PART I

PART I - ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

	HOSPICE COST CENTER (omit cents)	HOSPICE TRIAL BALANCE(1)	CAP BLDGS & FIXTURES	CAP MOVABLE EQUIPMENT	EMPLOYEE BENEFITS DEPARTMENT	COMMUNI- CATIONS	DATA PROCESSING	
		0	1	2	4	5.01	5.02	
1	ADMINISTRATIVE AND GENERAL		5,822	277	870,749			1
2	INPATIENT - GENERAL CARE							2
3	INPATIENT - RESPITE CARE							3
4	PHYSICIAN SERVICES	73,453						4
5	NURSING CARE	2,216,881						5
6	NURSING CARE-CONTINUOUS HOME CARE							6
7	PHYSICAL THERAPY	111,077						7
8	OCCUPATIONAL THERAPY							8
9	SPEECH/LANGUAGE PATHOLOGY	558						9
10	MEDICAL SOCIAL SERVICES	292,667						10
11	SPIRITUAL COUNSELING	55,291						11
12	DIETARY COUNSELING	20,882						12
13	COUNSELING - OTHER							13
14	HOME HEALTH AIDE AND HOMEMAKER	356,814						14
15	HH AIDE & HOMEMAKER - CONT. HOME							15
16	OTHER							16
17	DRUGS, BIOLOGICAL AND INFUSION TH	521,208						17
18	ANALGESICS							18
19	SEDATIVES / HYPNOTICS							19
20	OTHER - SPECIFY							20
21	DURABLE MED. EQUIPMENT/OXYGEN							21
22	PATIENT TRANSPORTATION							22
23	IMAGING SERVICES							23
24	LABS AND DIAGNOSTICS							24
25	MEDICAL SUPPLIES	11,419						25
26	OUTPATIENT SERVICES (including E/							26
27	RADIATION THERAPY							27
28	CHEMOTHERAPY							28
29	OTHER							29
30	BEREAVEMENT PROGRAM COSTS	60,216						30
31	VOLUNTEER PROGRAM COSTS							31
32	FUNDRAISING							32
33	OTHER PROGRAM COSTS							33
34	TOTALS (sum of lines 1-33) (2)	3,720,466	5,822	277	870,749			34
35	UNIT COST MULTIPLIER (see instruc							35

(1) Column 0, line 34 must agree with Wkst. A, column 7, line 116.

(2) Columns 0 through 25, line 34 must agree with the corresponding columns of Wkst. B, Part I, line 116.



PALOS COMMUNITY HOSPITAL Provider CCN: 14-0062	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 08:45 Version: 2014.03
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ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

HOSPICE CCN: 14-1591

WORKSHEET K-5
PART I

PART I - ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

	HOSPICE COST CENTER (omit cents)	PURCH & STORES	ADMITTING	CASHIERING	SUBTOTAL	ADMINIS- TRATIVE & GENERAL	MAIN- TENANCE & REPAIRS	
		5.03	5.04	5.05	4A	5.06	6	
1	ADMINISTRATIVE AND GENERAL	972			877,820	94,463	9,644	1
2	INPATIENT - GENERAL CARE							2
3	INPATIENT - RESPITE CARE							3
4	PHYSICIAN SERVICES				73,453	7,904		4
5	NURSING CARE				2,216,881	238,561		5
6	NURSING CARE-CONTINUOUS HOME CARE							6
7	PHYSICAL THERAPY				111,077	11,953		7
8	OCCUPATIONAL THERAPY							8
9	SPEECH/LANGUAGE PATHOLOGY				558	60		9
10	MEDICAL SOCIAL SERVICES				292,667	31,494		10
11	SPIRITUAL COUNSELING				55,291	5,950		11
12	DIETARY COUNSELING				20,882	2,247		12
13	COUNSELING - OTHER							13
14	HOME HEALTH AIDE AND HOMEMAKER				356,814	38,397		14
15	HH AIDE & HOMEMAKER - CONT. HOME							15
16	OTHER							16
17	DRUGS, BIOLOGICAL AND INFUSION TH				521,208	56,088		17
18	ANALGESICS							18
19	SEDATIVES / HYPNOTICS							19
20	OTHER - SPECIFY							20
21	DURABLE MED. EQUIPMENT/OXYGEN							21
22	PATIENT TRANSPORTATION							22
23	IMAGING SERVICES							23
24	LABS AND DIAGNOSTICS							24
25	MEDICAL SUPPLIES				11,419	1,229		25
26	OUTPATIENT SERVICES (including E/							26
27	RADIATION THERAPY							27
28	CHEMOTHERAPY							28
29	OTHER							29
30	BEREAVEMENT PROGRAM COSTS				60,216	6,480		30
31	VOLUNTEER PROGRAM COSTS							31
32	FUNDRAISING							32
33	OTHER PROGRAM COSTS							33
34	TOTALS (sum of lines 1-33) (2)	972			4,598,286	494,826	9,644	34
35	UNIT COST MULTIPLIER (see instruc							35

(1) Column 0, line 34 must agree with Wkst. A, column 7, line 116.

(2) Columns 0 through 25, line 34 must agree with the corresponding columns of Wkst. B, Part I, line 116.



PALOS COMMUNITY HOSPITAL Provider CCN: 14-0062	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 08:45 Version: 2014.03
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ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

HOSPICE CCN: 14-1591

WORKSHEET K-5
PART I

PART I - ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

	HOSPICE COST CENTER (omit cents)	CLINICAL ENGINEER	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSE- KEEPING	DIETARY	CAFETERIA	
		6.01	7	8	9	10	11	
1	ADMINISTRATIVE AND GENERAL							1
2	INPATIENT - GENERAL CARE							2
3	INPATIENT - RESPITE CARE							3
4	PHYSICIAN SERVICES							4
5	NURSING CARE							5
6	NURSING CARE-CONTINUOUS HOME CARE							6
7	PHYSICAL THERAPY							7
8	OCCUPATIONAL THERAPY							8
9	SPEECH/LANGUAGE PATHOLOGY							9
10	MEDICAL SOCIAL SERVICES							10
11	SPIRITUAL COUNSELING							11
12	DIETARY COUNSELING							12
13	COUNSELING - OTHER							13
14	HOME HEALTH AIDE AND HOMEMAKER							14
15	HH AIDE & HOMEMAKER - CONT. HOME							15
16	OTHER							16
17	DRUGS, BIOLOGICAL AND INFUSION TH							17
18	ANALGESICS							18
19	SEDATIVES / HYPNOTICS							19
20	OTHER - SPECIFY							20
21	DURABLE MED. EQUIPMENT/OXYGEN							21
22	PATIENT TRANSPORTATION							22
23	IMAGING SERVICES							23
24	LABS AND DIAGNOSTICS							24
25	MEDICAL SUPPLIES							25
26	OUTPATIENT SERVICES (including E/							26
27	RADIATION THERAPY							27
28	CHEMOTHERAPY							28
29	OTHER							29
30	BEREAVEMENT PROGRAM COSTS							30
31	VOLUNTEER PROGRAM COSTS							31
32	FUNDRAISING							32
33	OTHER PROGRAM COSTS							33
34	TOTALS (sum of lines 1-33) (2)							34
35	UNIT COST MULTIPLIER (see instruc							35

(1) Column 0, line 34 must agree with Wkst. A, column 7, line 116.

(2) Columns 0 through 25, line 34 must agree with the corresponding columns of Wkst. B, Part I, line 116.



PALOS COMMUNITY HOSPITAL Provider CCN: 14-0062	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 08:45 Version: 2014.03
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ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

HOSPICE CCN: 14-1591

WORKSHEET K-5
PART I

PART I - ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

	HOSPICE COST CENTER (omit cents)	MAIN- TENANCE OF PERSONNEL	NURSING ADMINIS- TRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	
		12	13	14	15	16	17	
1	ADMINISTRATIVE AND GENERAL			1,849	316,761			1
2	INPATIENT - GENERAL CARE							2
3	INPATIENT - RESPITE CARE							3
4	PHYSICIAN SERVICES							4
5	NURSING CARE							5
6	NURSING CARE-CONTINUOUS HOME CARE							6
7	PHYSICAL THERAPY							7
8	OCCUPATIONAL THERAPY							8
9	SPEECH/LANGUAGE PATHOLOGY							9
10	MEDICAL SOCIAL SERVICES							10
11	SPIRITUAL COUNSELING							11
12	DIETARY COUNSELING							12
13	COUNSELING - OTHER							13
14	HOME HEALTH AIDE AND HOMEMAKER							14
15	HH AIDE & HOMEMAKER - CONT. HOME							15
16	OTHER							16
17	DRUGS, BIOLOGICAL AND INFUSION TH							17
18	ANALGESICS							18
19	SEDATIVES / HYPNOTICS							19
20	OTHER - SPECIFY							20
21	DURABLE MED. EQUIPMENT/OXYGEN							21
22	PATIENT TRANSPORTATION							22
23	IMAGING SERVICES							23
24	LABS AND DIAGNOSTICS							24
25	MEDICAL SUPPLIES							25
26	OUTPATIENT SERVICES (including E/							26
27	RADIATION THERAPY							27
28	CHEMOTHERAPY							28
29	OTHER							29
30	BEREAVEMENT PROGRAM COSTS							30
31	VOLUNTEER PROGRAM COSTS							31
32	FUNDRAISING							32
33	OTHER PROGRAM COSTS							33
34	TOTALS (sum of lines 1-33) (2)			1,849	316,761			34
35	UNIT COST MULTIPLIER (see instruc							35

(1) Column 0, line 34 must agree with Wkst. A, column 7, line 116.

(2) Columns 0 through 25, line 34 must agree with the corresponding columns of Wkst. B, Part I, line 116.



PALOS COMMUNITY HOSPITAL Provider CCN: 14-0062	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 08:45 Version: 2014.03
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ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

HOSPICE CCN: 14-1591

WORKSHEET K-5
PART I

PART I - ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

	HOSPICE COST CENTER (omit cents)	NONPHYSIC. ANESTHET.	NURSING SCHOOL	I&R SALARY & FRINGES	I&R PROGRAM COSTS	PARAMED EDUCATION	SUBTOTAL (cols. 4A-23)	
		19	20	21	22	23	24	
1	ADMINISTRATIVE AND GENERAL						1,300,537	1
2	INPATIENT - GENERAL CARE							2
3	INPATIENT - RESPITE CARE							3
4	PHYSICIAN SERVICES						81,357	4
5	NURSING CARE						2,455,442	5
6	NURSING CARE-CONTINUOUS HOME CARE							6
7	PHYSICAL THERAPY						123,030	7
8	OCCUPATIONAL THERAPY							8
9	SPEECH/LANGUAGE PATHOLOGY						618	9
10	MEDICAL SOCIAL SERVICES						324,161	10
11	SPIRITUAL COUNSELING						61,241	11
12	DIETARY COUNSELING						23,129	12
13	COUNSELING - OTHER							13
14	HOME HEALTH AIDE AND HOMEMAKER						395,211	14
15	HH AIDE & HOMEMAKER - CONT. HOME							15
16	OTHER							16
17	DRUGS, BIOLOGICAL AND INFUSION TH						577,296	17
18	ANALGESICS							18
19	SEDATIVES / HYPNOTICS							19
20	OTHER - SPECIFY							20
21	DURABLE MED. EQUIPMENT/OXYGEN							21
22	PATIENT TRANSPORTATION							22
23	IMAGING SERVICES							23
24	LABS AND DIAGNOSTICS							24
25	MEDICAL SUPPLIES						12,648	25
26	OUTPATIENT SERVICES (including E/							26
27	RADIATION THERAPY							27
28	CHEMOTHERAPY							28
29	OTHER							29
30	BEREAVEMENT PROGRAM COSTS						66,696	30
31	VOLUNTEER PROGRAM COSTS							31
32	FUNDRAISING							32
33	OTHER PROGRAM COSTS							33
34	TOTALS (sum of lines 1-33) (2)						5,421,366	34
35	UNIT COST MULTIPLIER (see instruc							35

(1) Column 0, line 34 must agree with Wkst. A, column 7, line 116.

(2) Columns 0 through 25, line 34 must agree with the corresponding columns of Wkst. B, Part I, line 116.



PALOS COMMUNITY HOSPITAL Provider CCN: 14-0062	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 08:45 Version: 2014.03
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ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

HOSPICE CCN: 14-1591

WORKSHEET K-5
PART I

PART I - ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS

	HOSPICE COST CENTER (omit cents)	I&R COST & POST STEP- DOWN ADJS	SUBTOTAL (cols. 24 ± 25)	ALLOC HOSP A&G (See Part II)	TOTAL HOSP COSTS (col 26 ± 27)		
		25	26	27	28		
1	ADMINISTRATIVE AND GENERAL		1,300,537				1
2	INPATIENT - GENERAL CARE						2
3	INPATIENT - RESPITE CARE						3
4	PHYSICIAN SERVICES		81,357	25,676	107,033		4
5	NURSING CARE		2,455,442	774,939	3,230,381		5
6	NURSING CARE-CONTINUOUS HOME CARE						6
7	PHYSICAL THERAPY		123,030	38,828	161,858		7
8	OCCUPATIONAL THERAPY						8
9	SPEECH/LANGUAGE PATHOLOGY		618	195	813		9
10	MEDICAL SOCIAL SERVICES		324,161	102,306	426,467		10
11	SPIRITUAL COUNSELING		61,241	19,328	80,569		11
12	DIETARY COUNSELING		23,129	7,300	30,429		12
13	COUNSELING - OTHER						13
14	HOME HEALTH AIDE AND HOMEMAKER		395,211	124,729	519,940		14
15	HH AIDE & HOMEMAKER - CONT. HOME						15
16	OTHER						16
17	DRUGS, BIOLOGICAL AND INFUSION TH		577,296	182,195	759,491		17
18	ANALGESICS						18
19	SEDATIVES / HYPNOTICS						19
20	OTHER - SPECIFY						20
21	DURABLE MED. EQUIPMENT/OXYGEN						21
22	PATIENT TRANSPORTATION						22
23	IMAGING SERVICES						23
24	LABS AND DIAGNOSTICS						24
25	MEDICAL SUPPLIES		12,648	3,992	16,640		25
26	OUTPATIENT SERVICES (including E/						26
27	RADIATION THERAPY						27
28	CHEMOTHERAPY						28
29	OTHER						29
30	BEREAVEMENT PROGRAM COSTS		66,696	21,049	87,745		30
31	VOLUNTEER PROGRAM COSTS						31
32	FUNDRAISING						32
33	OTHER PROGRAM COSTS						33
34	TOTALS (sum of lines 1-33) (2)		5,421,366		5,421,366		34
35	UNIT COST MULTIPLIER (see instruc			0.315601			35

(1) Column 0, line 34 must agree with Wkst. A, column 7, line 116.

(2) Columns 0 through 25, line 34 must agree with the corresponding columns of Wkst. B, Part I, line 116.



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ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS - STATISTICAL BASIS HOSPICE CCN: 14-1591

WORKSHEET K-5
PART II

PART II - ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS - STATISTICAL BASIS

	HOSPICE COST CENTER	CAP BLDGS & FIXTURES SQUARE FEET	CAP MOVABLE EQUIPMENT DOLLAR VALUE	EMPLOYEE BENEFITS DEPARTMENT FTES	COMMUNICATIONS # OF PHONES	DATA PROCESSING TIME SPENT	PURCH & STORES # OF REQUISIT.	
		1	2	4	5.01	5.02	5.03	
1	ADMINISTRATIVE AND GENERAL	620	278	39			35	1
2	INPATIENT - GENERAL CARE							2
3	INPATIENT - RESPITE CARE							3
4	PHYSICIAN SERVICES							4
5	NURSING CARE							5
6	NURSING CARE-CONTINUOUS HOME CARE							6
7	PHYSICAL THERAPY							7
8	OCCUPATIONAL THERAPY							8
9	SPEECH/LANGUAGE PATHOLOGY							9
10	MEDICAL SOCIAL SERVICES							10
11	SPIRITUAL COUNSELING							11
12	DIETARY COUNSELING							12
13	COUNSELING - OTHER							13
14	HOME HEALTH AIDE AND HOME MAKER							14
15	HH AIDE & HOME MAKER - CONT. HOME							15
16	OTHER							16
17	DRUGS, BIOLOGICAL AND INFUSION TH							17
18	ANALGESICS							18
19	SEDATIVES / HYPNOTICS							19
20	OTHER - SPECIFY							20
21	DURABLE MED. EQUIPMENT/OXYGEN							21
22	PATIENT TRANSPORTATION							22
23	IMAGING SERVICES							23
24	LABS AND DIAGNOSTICS							24
25	MEDICAL SUPPLIES							25
26	OUTPATIENT SERVICES (including E/							26
27	RADIATION THERAPY							27
28	CHEMOTHERAPY							28
29	OTHER							29
30	BEREAVEMENT PROGRAM COSTS							30
31	VOLUNTEER PROGRAM COSTS							31
32	FUNDRAISING							32
33	OTHER PROGRAM COSTS							33
34	TOTALS (sum of lines 1-33)	620	278	39			35	34
35	TOTAL COST TO BE ALLOCATED	5,822	277	870,749			972	35
36	UNIT COST MULTIPLIER	9.390323		22,326.897436				36
36	UNIT COST MULTIPLIER		0.996403				27.771429	36



COMPU-MAX

PALOS COMMUNITY HOSPITAL Provider CCN: 14-0062	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 08:45 Version: 2014.03
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ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS - STATISTICAL BASIS HOSPICE CCN: 14-1591

WORKSHEET K-5
PART II

PART II - ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS - STATISTICAL BASIS

	HOSPICE COST CENTER	ADMITTING INPATIENT REVENUES	CASHIERING INPATIENT REVENUES	RECON- CILIATION 4A.06	ADMINIS- TRATIVE & GENERAL ACCUM COST 5.06	MAIN- TENANCE & REPAIRS SQUARE FEET 6 620	CLINICAL ENGINEER TIME SPENT 6.01		
1	ADMINISTRATIVE AND GENERAL	5.04	5.05	4A.06	5.06	877,820	620	6.01	1
2	INPATIENT - GENERAL CARE								2
3	INPATIENT - RESPITE CARE								3
4	PHYSICIAN SERVICES				73,453				4
5	NURSING CARE				2,216,881				5
6	NURSING CARE-CONTINUOUS HOME CARE								6
7	PHYSICAL THERAPY				111,077				7
8	OCCUPATIONAL THERAPY								8
9	SPEECH/LANGUAGE PATHOLOGY				558				9
10	MEDICAL SOCIAL SERVICES				292,667				10
11	SPIRITUAL COUNSELING				55,291				11
12	DIETARY COUNSELING				20,882				12
13	COUNSELING - OTHER								13
14	HOME HEALTH AIDE AND HOMEMAKER				356,814				14
15	HH AIDE & HOMEMAKER - CONT. HOME								15
16	OTHER								16
17	DRUGS, BIOLOGICAL AND INFUSION TH				521,208				17
18	ANALGESICS								18
19	SEDATIVES / HYPNOTICS								19
20	OTHER - SPECIFY								20
21	DURABLE MED. EQUIPMENT/OXYGEN								21
22	PATIENT TRANSPORTATION								22
23	IMAGING SERVICES								23
24	LABS AND DIAGNOSTICS								24
25	MEDICAL SUPPLIES				11,419				25
26	OUTPATIENT SERVICES (including E/								26
27	RADIATION THERAPY								27
28	CHEMOTHERAPY								28
29	OTHER								29
30	BEREAVEMENT PROGRAM COSTS				60,216				30
31	VOLUNTEER PROGRAM COSTS								31
32	FUNDRAISING								32
33	OTHER PROGRAM COSTS								33
34	TOTALS (sum of lines 1-33)				4,598,286	620			34
35	TOTAL COST TO BE ALLOCATED				494,826	9,644			35
36	UNIT COST MULTIPLIER					15.554839			36
36	UNIT COST MULTIPLIER				0.107611				36



PALOS COMMUNITY HOSPITAL Provider CCN: 14-0062	In Lieu of Form CMS-2552-10	Period : From: 01/01/2013 To: 12/31/2013	Run Date: 05/28/2014 Run Time: 08:45 Version: 2014.03
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ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS - STATISTICAL BASIS HOSPICE CCN: 14-1591

WORKSHEET K-5
PART II

PART II - ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS - STATISTICAL BASIS

	HOSPICE COST CENTER	OPERATION OF PLANT SQUARE FEET	LAUNDRY & LINEN SERVICE POUNDS OF LAUNDRY	HOUSE-KEEPING HOURS OF SERVICE	DIETARY MEALS SERVED	CAFETERIA FTES	MAIN-TENANCE OF PERSONNEL NUMBER HOUSED	
		7	8	9	10	11	12	
1	ADMINISTRATIVE AND GENERAL							1
2	INPATIENT - GENERAL CARE							2
3	INPATIENT - RESPITE CARE							3
4	PHYSICIAN SERVICES							4
5	NURSING CARE							5
6	NURSING CARE-CONTINUOUS HOME CARE							6
7	PHYSICAL THERAPY							7
8	OCCUPATIONAL THERAPY							8
9	SPEECH/LANGUAGE PATHOLOGY							9
10	MEDICAL SOCIAL SERVICES							10
11	SPIRITUAL COUNSELING							11
12	DIETARY COUNSELING							12
13	COUNSELING - OTHER							13
14	HOME HEALTH AIDE AND HOME MAKER							14
15	HH AIDE & HOME MAKER - CONT. HOME							15
16	OTHER							16
17	DRUGS, BIOLOGICAL AND INFUSION TH							17
18	ANALGESICS							18
19	SEDATIVES / HYPNOTICS							19
20	OTHER - SPECIFY							20
21	DURABLE MED. EQUIPMENT/OXYGEN							21
22	PATIENT TRANSPORTATION							22
23	IMAGING SERVICES							23
24	LABS AND DIAGNOSTICS							24
25	MEDICAL SUPPLIES							25
26	OUTPATIENT SERVICES (including E/							26
27	RADIATION THERAPY							27
28	CHEMOTHERAPY							28
29	OTHER							29
30	BEREAVEMENT PROGRAM COSTS							30
31	VOLUNTEER PROGRAM COSTS							31
32	FUNDRAISING							32
33	OTHER PROGRAM COSTS							33
34	TOTALS (sum of lines 1-33)							34
35	TOTAL COST TO BE ALLOCATED							35
36	UNIT COST MULTIPLIER							36
36	UNIT COST MULTIPLIER							36



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ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS - STATISTICAL BASIS HOSPICE CCN: 14-1591

WORKSHEET K-5
PART II

PART II - ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS - STATISTICAL BASIS

	HOSPICE COST CENTER	NURSING ADMINISTRATION FTES	CENTRAL SERVICES & SUPPLY COSTED REQUIS.	PHARMACY COSTED REQUIS.	MEDICAL RECORDS & LIBRARY TIME SPENT	SOCIAL SERVICE TIME SPENT	NONPHYSIC. ANESTHET. ASSIGNED TIME	
		13	14	15	16	17	19	
1	ADMINISTRATIVE AND GENERAL		2,477	355,195				1
2	INPATIENT - GENERAL CARE							2
3	INPATIENT - RESPITE CARE							3
4	PHYSICIAN SERVICES							4
5	NURSING CARE							5
6	NURSING CARE-CONTINUOUS HOME CARE							6
7	PHYSICAL THERAPY							7
8	OCCUPATIONAL THERAPY							8
9	SPEECH/LANGUAGE PATHOLOGY							9
10	MEDICAL SOCIAL SERVICES							10
11	SPIRITUAL COUNSELING							11
12	DIETARY COUNSELING							12
13	COUNSELING - OTHER							13
14	HOME HEALTH AIDE AND HOMEMAKER							14
15	HH AIDE & HOMEMAKER - CONT. HOME							15
16	OTHER							16
17	DRUGS, BIOLOGICAL AND INFUSION TH							17
18	ANALGESICS							18
19	SEDATIVES / HYPNOTICS							19
20	OTHER - SPECIFY							20
21	DURABLE MED. EQUIPMENT/OXYGEN							21
22	PATIENT TRANSPORTATION							22
23	IMAGING SERVICES							23
24	LABS AND DIAGNOSTICS							24
25	MEDICAL SUPPLIES							25
26	OUTPATIENT SERVICES (including E/							26
27	RADIATION THERAPY							27
28	CHEMOTHERAPY							28
29	OTHER							29
30	BEREAVEMENT PROGRAM COSTS							30
31	VOLUNTEER PROGRAM COSTS							31
32	FUNDRAISING							32
33	OTHER PROGRAM COSTS							33
34	TOTALS (sum of lines 1-33)		2,477	355,195				34
35	TOTAL COST TO BE ALLOCATED		1,849	316,761				35
36	UNIT COST MULTIPLIER			0.891795				36
36	UNIT COST MULTIPLIER		0.746468					36



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ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS - STATISTICAL BASIS HOSPICE CCN: 14-1591

WORKSHEET K-5
PART II

PART II - ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS - STATISTICAL BASIS

	HOSPICE COST CENTER	NURSING SCHOOL ASSIGNED TIME	I&R SALARY & FRINGES ASSIGNED TIME	I&R PROGRAM COSTS ASSIGNED TIME	PARAMED EDUCATION ASSIGNED TIME			
		20	21	22	23			
1	ADMINISTRATIVE AND GENERAL							1
2	INPATIENT - GENERAL CARE							2
3	INPATIENT - RESPITE CARE							3
4	PHYSICIAN SERVICES							4
5	NURSING CARE							5
6	NURSING CARE-CONTINUOUS HOME CARE							6
7	PHYSICAL THERAPY							7
8	OCCUPATIONAL THERAPY							8
9	SPEECH/LANGUAGE PATHOLOGY							9
10	MEDICAL SOCIAL SERVICES							10
11	SPIRITUAL COUNSELING							11
12	DIETARY COUNSELING							12
13	COUNSELING - OTHER							13
14	HOME HEALTH AIDE AND HOME MAKER							14
15	HH AIDE & HOME MAKER - CONT. HOME							15
16	OTHER							16
17	DRUGS, BIOLOGICAL AND INFUSION TH							17
18	ANALGESICS							18
19	SEDATIVES / HYPNOTICS							19
20	OTHER - SPECIFY							20
21	DURABLE MED. EQUIPMENT/OXYGEN							21
22	PATIENT TRANSPORTATION							22
23	IMAGING SERVICES							23
24	LABS AND DIAGNOSTICS							24
25	MEDICAL SUPPLIES							25
26	OUTPATIENT SERVICES (including E/							26
27	RADIATION THERAPY							27
28	CHEMOTHERAPY							28
29	OTHER							29
30	BEREAVEMENT PROGRAM COSTS							30
31	VOLUNTEER PROGRAM COSTS							31
32	FUNDRAISING							32
33	OTHER PROGRAM COSTS							33
34	TOTALS (sum of lines 1-33)							34
35	TOTAL COST TO BE ALLOCATED							35
36	UNIT COST MULTIPLIER							36
36	UNIT COST MULTIPLIER							36



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APPORTIONMENT OF HOSPICE SHARED SERVICES

HOSPICE CCN: 14-1591

WORKSHEET K-5
PART III

PART III - COMPUTATION OF TOTAL HOSPICE SHARED COSTS

	COST CENTER	WKST C, PART I, COL. 9, LINE	COST TO CHARGE RATIO	TOTAL HOSPICE CHARGES (Provider Records)	HOSPICE SHARED ANCILLARY COSTS (cols. 1 x 2)	
		0	1	2	3	
	ANCILLARY SERVICE COST CENTERS					
1	PHYSICAL THERAPY	66	0.347987	1,997	695	1
2	OCCUPATIONAL THERAPY	67				2
3	SPEECH/LANGUAGE PATHOLOGY	68	0.206348			3
4	DRUGS, BIOLOGICAL AND INFUSION THERAPY	73	0.333952	216,274	72,225	4
5	DURABLE MEDICAL EQUIPMENT/OXYGEN	96				5
6	LABS AND DIAGNOSTICS	60	0.095106	15,415	1,466	6
7	MEDICAL SUPPLIES	71	0.198522	50,104	9,947	7
8	OUTPATIENT SERVICES (including E/R Dept.)	93		18,707		8
9	RADIATION THERAPY	55				9
10	OTHER ANCILLARY (SPECIFY)	76				10
10.97	CARDIAC REHABILITATION	76.97	0.430299			10.97
10.98	HYPERBARIC OXYGEN THERAPY	76.98				10.98
10.99	LITHOTRIPSY	76.99				10.99
11	TOTALS (sum of lines 1-10)				84,333	11



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CALCULATION OF HOSPICE PER DIEM COST

HOSPICE CCN: 14-1591

WORKSHEET K-6

COMPUTATION OF PER DIEM COSTS		TITLE XVIII	TITLE XIX	OTHER	TOTAL	
		1	2	3	4	
1	TOTAL COST (see instructions)				5,505,699	1
2	TOTAL UNDUPLICATED DAYS (Worksheet S-9, column 6, line 5)				37,740	2
3	AVERAGE COST PER DIEM (line 1 divided by line 2)				145.88	3
4	UNDUPLICATED MEDICARE DAYS (Worksheet S-9, column 1, line 5)	35,727				4
5	AGGREGATE MEDICARE COST (line 3 times line 4)	5,211,855				5
6	UNDUPLICATED MEDICAID DAYS (Worksheet S-9, column 2, line 5)		56			6
7	AGGREGATE MEDICAID COST (line 3 times line 6)		8,169			7
8	UNDUPLICATED SNF DAYS (Worksheet S-9, column 3, line 5)	8,319				8
9	AGGREGATE SNF COST (line 3 times line 8)	1,213,576				9
10	UNDUPLICATED NF DAYS (Worksheet S-9, column 4, line 5)		7			10
11	AGGREGATE NF COST (line 3 times line 10)		1,021			11
12	OTHER UNDUPLICATED DAYS (Worksheet S-9, column 5, line 5)			1,957		12
13	AGGREGATE COST FOR OTHER DAYS (line 3 times line 12)			285,487		13

Note: The data for the SNF and NF on lines 8 through 11 are included in the Medicare and Medicaid lines 4 through 7.



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CALCULATION OF CAPITAL PAYMENT

COMPONENT CCN: 14-0062

WORKSHEET L

CHECK TITLE V HOSPITAL PPS
 APPLICABLE TITLE XVIII, PART A SUB (OTHER) COST METHOD
 BOXES: TITLE XIX

PART I - FULLY PROSPECTIVE METHOD

1	CAPITAL FEDERAL AMOUNT		
1	CAPITAL DRG OTHER THAN OUTLIER		1
1.01	MODEL 4 BPCI CAPITAL DRG OTHER THAN OUTLIER		1.01
2	CAPITAL DRG OUTLIER PAYMENTS		2
2.01	MODEL 4 BPCI CAPITAL DRG OUTLIER PAYMENTS		2.01
3	TOTAL INPATIENT DAYS DIVIDED BY NUMBER OF DAYS IN THE COST REPORTING PERIOD (see instructions)		3
4	NUMBER OF INTERNS & RESIDENTS (see instructions)		4
5	INDIRECT MEDICAL EDUCATION PERCENTAGE (see instructions)		5
6	INDIRECT MEDICAL EDUCATION ADJUSTMENT (multiply line 5 by the sum of lines 1 and 1.01)		6
7	PERCENTAGE OF SSI RECIPIENT PATIENT DAYS TO MEDICARE PART A PATIENT DAYS (Worksheet E, Part A line 30) (see instructions)		7
8	PERCENTAGE OF MEDICAID PATIENT DAYS TO TOTAL DAYS (see instructions)		8
9	SUM OF LINES 7 AND 8		9
10	ALLOWABLE DISPROPORTIONATE SHARE PERCENTAGE (see instructions)		10
11	DISPROPORTIONATE SHARE ADJUSTMENT (line 10 times the sum of lines 1 and 1.01)		11
12	TOTAL PROSPECTIVE CAPITAL PAYMENTS (sum of lines 1, 1.01, 2, 2.01, 6 and 11)		12

PART II - PAYMENT UNDER REASONABLE COST

1	PROGRAM INPATIENT ROUTINE CAPITAL COST (see instructions)		1
2	PROGRAM INPATIENT ANCILLARY CAPITAL COST (see instructions)		2
3	TOTAL INPATIENT PROGRAM CAPITAL COST (line 1 plus line 2)		3
4	CAPITAL COST PAYMENT FACTOR (see instructions)		4
5	TOTAL INPATIENT PROGRAM CAPITAL COST (line 3 times line 4)		5

PART III - COMPUTATION OF EXCEPTION PAYMENTS

1	PROGRAM INPATIENT CAPITAL COSTS (see instructions)		1
2	PROGRAM INPATIENT CAPITAL COSTS FOR EXTRAORDINARY CIRCUMSTANCES (see instructions)		2
3	NET PROGRAM INPATIENT CAPITAL COSTS (line 1 minus line 2)		3
4	APPLICABLE EXCEPTION PERCENTAGE (see instructions)		4
5	CAPITAL COST FOR COMPARISON TO PAYMENTS (line 3 x line 4)		5
6	PERCENTAGE ADJUSTMENT FOR EXTRAORDINARY CIRCUMSTANCES (see instructions)		6
7	ADJUSTMENT TO CAPITAL MINIMUM PAYMENT LEVEL FOR EXTRAORDINARY CIRCUMSTANCES (line 2 x line 6)		7
8	CAPITAL MINIMUM PAYMENT LEVEL (line 5 plus line 7)		8
9	CURRENT YEAR CAPITAL PAYMENTS (from Part I, line 12 as applicable)		9
10	CURRENT YEAR COMPARISON OF CAPITAL MINIMUM PAYMENT LEVEL TO CAPITAL PAYMENTS (line 8 less line 9)		10
11	CARRYOVER OF ACCUMULATED CAPITAL MINIMUM PAYMENT LEVEL OVER CAPITAL PAYMENT (from prior year Worksheet L, Part III, line 14)		11
12	NET COMPARISON OF CAPITAL MINIMUM PAYMENT LEVEL TO CAPITAL PAYMENTS (line 10 plus line 11)		12
13	CURRENT YEAR EXCEPTION PAYMENT (if line 12 is positive, enter the amount on this line)		13
14	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)		14
15	CURRENT YEAR ALLOWABLE OPERATING AND CAPITAL PAYMENT (see instructions)		15
16	CURRENT YEAR OPERATING AND CAPITAL COSTS (see instructions)		16
17	CURRENT YEAR EXCEPTION OFFSET AMOUNT (see instructions)		17



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ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
PART I

	COST CENTER DESCRIPTIONS	EXTRAORDINARY CAP-REL COSTS	SUBTOTAL (cols.0-4)	SUBTOTAL	I&R COST & POST STEP-DOWN ADJS	TOTAL	
		0	2A	24	25	26	
	GENERAL SERVICE COST CENTERS						
1	CAP REL COSTS-BLDG & FIXT						1
2	CAP REL COSTS-MVBLE EQUIP						2
4	EMPLOYEE BENEFITS DEPARTMENT						4
5.01	COMMUNICATIONS						5.01
5.02	DATA PROCESSING						5.02
5.03	PURCHASING & STORES						5.03
5.04	ADMITTING						5.04
5.05	CASHIERING						5.05
5.06	ADMINISTRATIVE & GENERAL						5.06
6	MAINTENANCE & REPAIRS						6
6.01	CLINICAL ENGINEERING						6.01
7	OPERATION OF PLANT						7
8	LAUNDRY & LINEN SERVICE						8
9	HOUSEKEEPING						9
10	DIETARY						10
11	CAFETERIA						11
12	MAINTENANCE OF PERSONNEL						12
13	NURSING ADMINISTRATION						13
14	CENTRAL SERVICES & SUPPLY						14
15	PHARMACY						15
16	MEDICAL RECORDS & LIBRARY						16
17	SOCIAL SERVICE						17
19	NONPHYSICIAN ANESTHETISTS						19
20	NURSING SCHOOL						20
21	I&R SERVICES-SALARY & FRINGES APPRVD						21
22	I&R SERVICES-OTHER PRGM COSTS APPRVD						22
23	PARAMED ED PRGM-PHARMACY RESIDENCY						23
	INPATIENT ROUTINE SERV COST CENTERS						
30	ADULTS & PEDIATRICS						30
31	INTENSIVE CARE UNIT						31
40	SUBPROVIDER - IPF						40
43	NURSERY						43
	ANCILLARY SERVICE COST CENTERS						
50	OPERATING ROOM						50
51	RECOVERY ROOM						51
53	ANESTHESIOLOGY						53
54	RADIOLOGY-DIAGNOSTIC						54
54.01	ULTRASOUND						54.01
57	CT SCAN						57
58	MRI						58
59	CARDIAC CATHETERIZATION						59
60	LABORATORY						60
62.30	BLOOD CLOTTING FOR HEMOPHILIACS						62.30
63	BLOOD STORING, PROCESSING & TRANS.						63
64	INTRAVENOUS THERAPY						64
65	RESPIRATORY THERAPY						65
66	PHYSICAL THERAPY						66
68	SPEECH PATHOLOGY						68
69	ELECTROCARDIOLOGY						69
70	ELECTROENCEPHALOGRAPHY						70
70.01	EMG						70.01
70.03	ANGIOGRAPHY						70.03
71	MEDICAL SUPPLIES CHARGED TO PATIENTS						71
72	IMPL. DEV. CHARGED TO PATIENTS						72
73	DRUGS CHARGED TO PATIENTS						73
74	RENAL DIALYSIS						74
76.97	CARDIAC REHABILITATION						76.97
76.98	HYPERBARIC OXYGEN THERAPY						76.98
76.99	LITHOTRIPSY						76.99
	OUTPATIENT SERVICE COST CENTERS						
90.01	OUTPATIENT PSYCHE SERVICES						90.01
91	EMERGENCY						91
91.01	PCC						91.01
92	OBSERVATION BEDS (NON-DISTINCT PART)						92
	OTHER REIMBURSABLE COST CENTERS						
101	HOME HEALTH AGENCY						101
	SPECIAL PURPOSE COST CENTERS						
113	INTEREST EXPENSE						113
116	HOSPICE						116
118	SUBTOTALS (sum of lines 1-117)						118
	NONREIMBURSABLE COST CENTERS						
190	GIFT, FLOWER, COFFEE SHOP & CANTEEN						190
192	PHYSICIANS' PRIVATE OFFICES						192
194	NEW DIRECTION						194



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ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES

WORKSHEET L-1
PART I

	COST CENTER DESCRIPTIONS	EXTRAORDI- NARY CAP- REL COSTS	SUBTOTAL (cols.0-4) 2A	SUBTOTAL 24	I&R COST & POST STEP- DOWN ADJS 25	TOTAL 26		
194.01	PRIVATE DUTY NURSING	0	2A	24	25	26		194.01
194.02	PHYSICIAN REFERRAL CENTER							194.02
200	CROSS FOOT ADJUSTMENTS							200
201	NEGATIVE COST CENTER							201
202	TOTAL (sum of lines 118-201)							202