

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 143027	Period: From 07/01/2012 To 06/30/2013	Worksheet S Parts I-III Date/Time Prepared: 11/20/2013 11:03 am
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PART I - COST REPORT STATUS			
Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 11/20/2013	Time: 11:03 am
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN	10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by MARIANJOY REHAB HOSPITAL & CLINIC (143027) for the cost reporting period beginning 07/01/2012 and ending 06/30/2013 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

 Title

 Date

Cost Center Description	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	120,441	15,458	0	0	1.00
2.00 Subprovider - IPF	0	0	0	0	0	2.00
3.00 Subprovider - IRF	0	0	0	0	0	3.00
5.00 Swing bed - SNF	0	0	0	0	0	5.00
6.00 Swing bed - NF	0	0	0	0	0	6.00
7.00 SKILLED NURSING FACILITY	0	1,276	0	0	0	7.00
200.00 Total	0	121,717	15,458	0	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 143027	Period: From 07/01/2012 To 06/30/2013	Worksheet S-2 Part I Date/Time Prepared: 11/20/2013 11:00 am
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1.00	2.00	3.00	4.00
Hospital and Hospital Health Care Complex Address:			
1.00 Street: 26W171 ROOSEVELT ROAD	PO Box:		
2.00 City: WHEATON	State: IL	Zip Code: 60187	County: DUPAGE

	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)		
						V	XVIII	XIX
1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	

Hospital and Hospital-Based Component Identification:								
3.00 Hospital	MARIANJOY REHAB HOSPITAL & CLINIC	143027	16974	5	01/01/1973	N	P	N
4.00 Subprovider - IPF								
5.00 Subprovider - IRF								
6.00 Subprovider - (Other)								
7.00 Swing Beds - SNF								
8.00 Swing Beds - NF								
9.00 Hospital-Based SNF	MARIANJOY REHAB HOSPITAL & CLINIC	146129	16974		12/18/2008	N	P	N
10.00 Hospital-Based NF								
11.00 Hospital-Based OLTC								
12.00 Hospital-Based HHA								
13.00 Separately Certified ASC								
14.00 Hospital-Based Hospice								
15.00 Hospital-Based Health Clinic - RHC								
16.00 Hospital-Based Health Clinic - FQHC								
17.00 Hospital-Based (CMHC) I								
18.00 Renal Dialysis								
19.00 Other								

		From:	To:
		1.00	2.00
20.00 Cost Reporting Period (mm/dd/yyyy)		07/01/2012	06/30/2013
21.00 Type of Control (see instructions)		2	

Inpatient PPS Information			
22.00 Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital)? In column 2, enter "Y" for yes or "N" for no.		N	N
23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.		3	N

	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days
24.00 If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	0	0	0	0	0	0
25.00 If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.	1,482	0	0	0	1,467	0

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

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		Beginning: 1.00	Ending: 2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0				37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.					38.00
		Y/N 1.00	Y/N 2.00			
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					39.00
		V 1.00	XVIII 2.00	XIX 3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	N	N		45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N		46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N		47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N		48.00
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	Y				56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.	N				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.	N				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N				59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	N				60.00
		Y/N 1.00	IME 2.00	Direct GME 3.00	IME 4.00	Direct GME 5.00
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N			0.00	0.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00		61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN and general surgery) added as a result of section 5503. (see instructions)		0.00	0.00		61.02
61.03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00		61.03
61.04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00		61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0.00	0.00		61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.00		61.06
		Program Name 1.00	Program Code 2.00	Unweighted IME FTE Count 3.00	Unweighted Direct GME FTE Count 4.00	
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1 the program name, enter in column 2 the program code, enter in column 3 the IME FTE unweighted count and enter in column 4 direct GME FTE unweighted count.			0.00	0.00	61.10

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

				1.00	
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ACA Provisions Affecting the Health Resources and Services Administration (HRSA)					
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)			0.00	62.00

62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)			0.00	62.01
Teaching Hospitals that Claim Residents in Non-Provider Settings					

63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)			N	63.00
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	Unweighted FTEs Nonprovi der Si te	Unweighted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))	

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

	Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospi tal	Ratio (col. 3/ (col. 3 + col. 4))	

65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000	65.00
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	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))	

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

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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))		
					1.00	2.00	3.00
67.00	Enter in column 1 the program name associated with each of your primary care programs in which you trained residents. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000		67.00
					1.00	2.00	3.00
Inpatient Psychiatric Facility PPS							
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.			N			70.00
71.00	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 or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)					0	71.00
Inpatient Rehabilitation Facility PPS							
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.			Y			75.00
76.00	If line 75 yes: Column 1: Did the facility have a teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR §412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2 or 3 respectively in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the 5th or subsequent academic years of the new teaching program in existence, enter 5. (see instructions)			Y	N	4	76.00
					1.00		
Long Term Care Hospital PPS							
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.					N	80.00
TEFRA Providers							
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.					N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.						86.00
					V	XIX	
					1.00	2.00	
Title V and XIX Services							
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.			N		Y	90.00
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.			N		N	91.00
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.					N	92.00
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.			N		N	93.00
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.			N		N	94.00
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.				0.00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.			N		N	96.00
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.				0.00	0.00	97.00
Rural Providers							
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?			N			105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)						106.00

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		V	XIX			
		1.00	2.00			
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)				107.00	
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N			108.00	
		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00
		1.00	2.00	3.00		
Miscellaneous Cost Reporting Information						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.		N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.		N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.		Y			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.		2			118.00
		Premiums	Losses	Insurance		
		1.00	2.00	3.00		
118.01	List amounts of malpractice premiums and paid losses:	182,725	0	0		118.01
		1.00	2.00			
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N			118.02
119.00	DO NOT USE THIS LINE					119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.		N		N	120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.		N			121.00
Transplant Center Information						
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N			125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.					133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.					134.00
All Providers						
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)		Y		14H016	140.00

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1.00		2.00		3.00		
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.						
141.00	Name: WHEATON FRANCISCAN HEALTHCARE	Contractor's Name: NGS		Contractor's Number: 00450		141.00
142.00	Street: P.O. BOX 667	PO Box:				142.00
143.00	City: WHEATON	State: IL	Zip Code: 60187			143.00

		1.00	
144.00	Are provider based physicians' costs included in Worksheet A?	Y	144.00
145.00	If costs for renal services are claimed on Worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.	Y	145.00

		1.00	2.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	N		147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.	N		148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.	N		149.00

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

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

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

		1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act			
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.	N	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)		0.00
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)		0.00

		1.00	2.00	
		Beginning	Ending	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)			170.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 143027	Period: From 07/01/2012 To 06/30/2013	Worksheet S-2 Part II Date/Time Prepared: 11/20/2013 11:00 am	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	N			3.00
			Y/N	Type	Date
			1.00	2.00	3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	N			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	Y			9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
				Y/N	
				1.00	
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
		Y/N	Date	Y/N	
		1.00	2.00	3.00	
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 143027	Period: From 07/01/2012 To 06/30/2013	Worksheet S-2 Part II Date/Time Prepared: 11/20/2013 11:00 am	
	Description	Part A		Part B	
		Y/N	Date	Y/N	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	0	1.00	2.00	3.00
		N			N
					21.00
					1.00
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS)					
Capital Related Cost					
22.00	Have assets been relieved for Medicare purposes? If yes, see instructions				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
					Y/N
					Date
					1.00
					2.00
Home Office Costs					
36.00	Were home office costs claimed on the cost report?				36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.		N		38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
					1.00
					2.00
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	ROY		D' SILVA	41.00
42.00	Enter the employer/company name of the cost report preparer.	MARIANJOY REHABILITATION HOSPITAL			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	630-909-7320		RD' SILVA@MARIANJOY.ORG	43.00

		Part B	
		Date	
		4.00	
PS&R Data			
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)		16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.		18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:		20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.		21.00
		3.00	
Cost Report Preparer Contact Information			
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	ACCOUNTING & REIMBURSEMENT MANAGER	41.00
42.00	Enter the employer/company name of the cost report preparer.		42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.		43.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 143027

Period:
From 07/01/2012
To 06/30/2013

Worksheet S-3
Part I
Date/Time Prepared:
11/20/2013 11:00 am

Component	Worksheet A Line Number	No. of Beds	Bed Days Avai lable	CAH Hours	I/P Days / O/P Vi si ts / Tri ps	
					Title V	
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	101	38,993	0.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		101	38,993	0.00	0	7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)		101	38,993	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	44.00	27	7,727		0	19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE	46.00	0	0			21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		128				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 143027

Period:
From 07/01/2012
To 06/30/2013

Worksheet S-3
Part I
Date/Time Prepared:
11/20/2013 11:00 am

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	20,401	1,482	32,239			1.00
2.00 HMO and other (see instructions)	7	1,467				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	20,401	1,482	32,239			7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	20,401	1,482	32,239	14.88	563.77	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	5,058	0	7,402	0.00	28.79	19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE			0	0.00	0.00	21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)				14.88	592.56	27.00
28.00 Observation Bed Days		0	0			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
33.00 LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 143027

Period:
From 07/01/2012
To 06/30/2013

Worksheet S-3
Part I
Date/Time Prepared:
11/20/2013 11:00 am

Component	Full Time Equivalents	Discharges			Total All Patients	
		Title V	Title XVIII	Title XIX		
		11.00	12.00	13.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1,588	80	2,833	1.00
2.00 HMO and other (see instructions)			0			2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	1,588	80	2,833	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY	0.00					19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE	0.00				0	21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION			Provider CCN: 143027		Period: From 07/01/2012 To 06/30/2013		Worksheet S-3 Part II Date/Time Prepared: 11/20/2013 11:00 am	
	Worksheet A Line Number	Amount Reported	Reclassification of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)		
	1.00	2.00	3.00	4.00	5.00	6.00		
PART II - WAGE DATA								
SALARIES								
1.00	Total salaries (see instructions)	200.00	37,400,351	0	37,400,351	1,263,478.48	29.60	1.00
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00	2.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00	3.00
4.00	Physician-Part A - Administrative		0	0	0	0.00	0.00	4.00
4.01	Physicians - Part A - Teaching		0	0	0	0.00	0.00	4.01
5.00	Physician-Part B		0	0	0	0.00	0.00	5.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00	6.00
7.00	Interns & residents (in an approved program)	21.00	976,736	50,827	1,027,563	30,950.00	33.20	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	1,744,319	-94,633	1,649,686	59,879.40	27.55	9.00
10.00	Excluded area salaries (see instructions)		5,994,926	0	5,994,926	166,492.05	36.01	10.00
OTHER WAGES & RELATED COSTS								
11.00	Contract labor (see instructions)		122,752	0	122,752	1,889.00	64.98	11.00
12.00	Contract management and administrative services		162,168	0	162,168	1,187.00	136.62	12.00
13.00	Contract Labor: Physician-Part A - Administrative		0	0	0	0.00	0.00	13.00
14.00	Home office salaries & wage-related costs		0	0	0	0.00	0.00	14.00
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00	15.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00	16.00
WAGE-RELATED COSTS								
17.00	Wage-related costs (core) (see instructions)		0	0	0			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		5,994,926	0	5,994,926			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FOHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	50,993	-11,302	39,691	1,178.00	33.69	26.00
27.00	Administrative & General	5.00	5,973,067	-949,794	5,023,273	207,667.60	24.19	27.00
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	301,688	0	301,688	16,083.75	18.76	30.00
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00	31.00
32.00	Housekeeping	9.00	701,239	0	701,239	44,902.25	15.62	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	1,095,216	0	1,095,216	65,228.25	16.79	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	517,178	-96	517,082	16,008.00	32.30	38.00
39.00	Central Services and Supply	14.00	161,845	0	161,845	10,469.50	15.46	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	1,003,807	0	1,003,807	47,425.50	21.17	41.00

HOSPITAL WAGE INDEX INFORMATION		Worksheet A		Amount		Reclassification of Salaries		Adjusted Salaries		Paid Hours		Average Hourly Wage	
		Line Number	Reported	(from Worksheet A-6)	(col. 2 ± col. 3)							(col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00		6.00					
42.00	Social Service	17.00	0	832,345	832,345	18,141.50		45.88				42.00	
43.00	Other General Service	18.00	74,145	0	74,145	3,370.00		22.00				43.00	

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 143027

Period:
From 07/01/2012
To 06/30/2013

Worksheet S-3
Part III
Date/Time Prepared:
11/20/2013 11:00 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	36,423,615	-50,827	36,372,788	1,232,528.48	29.51	1.00
2.00	Excluded area salaries (see instructions)	7,739,245	-94,633	7,644,612	226,371.45	33.77	2.00
3.00	Subtotal salaries (line 1 minus line 2)	28,684,370	43,806	28,728,176	1,006,157.03	28.55	3.00
4.00	Subtotal other wages & related costs (see inst.)	284,920	0	284,920	3,076.00	92.63	4.00
5.00	Subtotal wage-related costs (see inst.)	0	0	0	0.00	0.00	5.00
6.00	Total (sum of lines 3 thru 5)	28,969,290	43,806	29,013,096	1,009,233.03	28.75	6.00
7.00	Total overhead cost (see instructions)	9,879,178	-128,847	9,750,331	430,474.35	22.65	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 143027	Period: From 07/01/2012 To 06/30/2013	Worksheet S-3 Part IV Date/Time Prepared: 11/20/2013 11:00 am
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions			0 1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution			0 2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)			0 3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)			0 4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration Fees			0 5.00
6.00	Legal/Accounting/Management Fees-Pension Plan			0 6.00
7.00	Employee Managed Care Program Administration Fees			0 7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)			0 8.00
9.00	Prescription Drug Plan			0 9.00
10.00	Dental, Hearing and Vision Plan			0 10.00
11.00	Life Insurance (If employee is owner or beneficiary)			0 11.00
12.00	Accident Insurance (If employee is owner or beneficiary)			0 12.00
13.00	Disability Insurance (If employee is owner or beneficiary)			0 13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)			0 14.00
15.00	'Workers' Compensation Insurance			0 15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)			0 16.00
TAXES				
17.00	FICA-Employers Portion Only			0 17.00
18.00	Medicare Taxes - Employers Portion Only			0 18.00
19.00	Unemployment Insurance			0 19.00
20.00	State or Federal Unemployment Taxes			0 20.00
OTHER				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))			0 21.00
22.00	Day Care Cost and Allowances			0 22.00
23.00	Tuition Reimbursement			0 23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)			0 24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)			0 25.00

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 143027

Period:
From 07/01/2012
To 06/30/2013

Worksheet S-7

Date/Time Prepared:
11/20/2013 11:00 am

		1.00	2.00	
1.00	If this facility contains a hospital-based SNF, were all patients under managed care or was there no Medicare utilization? Enter "Y" for yes in column 1 and do not complete the rest of this worksheet.	N		1.00
2.00	Does this hospital have an agreement under either section 1883 or section 1913 for swing beds? Enter "Y" for yes or "N" for no in column 1. If yes, enter the agreement date (mm/dd/yyyy) in column 2.	N		2.00

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
3.00		RUX	0	0	0	3.00
4.00		RUL	0	0	0	4.00
5.00		RVX	0	0	0	5.00
6.00		RVL	0	0	0	6.00
7.00		RHX	0	0	0	7.00
8.00		RHL	0	0	0	8.00
9.00		RMX	0	0	0	9.00
10.00		RML	0	0	0	10.00
11.00		RLX	0	0	0	11.00
12.00		RUC	70	0	70	12.00
13.00		RUB	504	0	504	13.00
14.00		RUA	4,056	0	4,056	14.00
15.00		RVC	0	0	0	15.00
16.00		RVB	52	0	52	16.00
17.00		RVA	275	0	275	17.00
18.00		RHC	0	0	0	18.00
19.00		RHB	0	0	0	19.00
20.00		RHA	32	0	32	20.00
21.00		RMC	0	0	0	21.00
22.00		RMB	10	0	10	22.00
23.00		RMA	53	0	53	23.00
24.00		RLB	0	0	0	24.00
25.00		RLA	0	0	0	25.00
26.00		ES3	0	0	0	26.00
27.00		ES2	0	0	0	27.00
28.00		ES1	0	0	0	28.00
29.00		HE2	0	0	0	29.00
30.00		HE1	0	0	0	30.00
31.00		HD2	0	0	0	31.00
32.00		HD1	0	0	0	32.00
33.00		HC2	0	0	0	33.00
34.00		HC1	0	0	0	34.00
35.00		HB2	0	0	0	35.00
36.00		HB1	0	0	0	36.00
37.00		LE2	0	0	0	37.00
38.00		LE1	0	0	0	38.00
39.00		LD2	0	0	0	39.00
40.00		LD1	0	0	0	40.00
41.00		LC2	0	0	0	41.00
42.00		LC1	0	0	0	42.00
43.00		LB2	0	0	0	43.00
44.00		LB1	0	0	0	44.00
45.00		CE2	0	0	0	45.00
46.00		CE1	0	0	0	46.00
47.00		CD2	0	0	0	47.00
48.00		CD1	0	0	0	48.00
49.00		CC2	0	0	0	49.00
50.00		CC1	1	0	1	50.00
51.00		CB2	0	0	0	51.00
52.00		CB1	2	0	2	52.00
53.00		CA2	0	0	0	53.00
54.00		CA1	0	0	0	54.00
55.00		SE3	0	0	0	55.00
56.00		SE2	0	0	0	56.00
57.00		SE1	0	0	0	57.00
58.00		SSC	0	0	0	58.00
59.00		SSB	0	0	0	59.00
60.00		SSA	0	0	0	60.00
61.00		IB2	0	0	0	61.00
62.00		IB1	0	0	0	62.00
63.00		IA2	0	0	0	63.00
64.00		IA1	0	0	0	64.00
65.00		BB2	0	0	0	65.00
66.00		BB1	0	0	0	66.00
67.00		BA2	0	0	0	67.00
68.00		BA1	0	0	0	68.00

11/20/2013 11:00 am

PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA

Provider CCN: 143027

Period:
From 07/01/2012
To 06/30/2013

Worksheet S-7

Date/Time Prepared:
11/20/2013 11:00 am

		Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
		1.00	2.00	3.00	4.00	
69.00		PE2	0	0	0	69.00
70.00		PE1	0	0	0	70.00
71.00		PD2	0	0	0	71.00
72.00		PD1	0	0	0	72.00
73.00		PC2	0	0	0	73.00
74.00		PC1	0	0	0	74.00
75.00		PB2	0	0	0	75.00
76.00		PB1	2	0	2	76.00
77.00		PA2	0	0	0	77.00
78.00		PA1	0	0	0	78.00
199.00		AAA	1	0	1	199.00
200.00	TOTAL		5,058	0	5,058	200.00

		CBSA at Beginning of Cost Reporting Period	CBSA on/after October 1 of the Cost Reporting Period (if applicable)
		1.00	2.00

201.00 SNF SERVICES
 Enter in column 1 the SNF CBSA code or 5 character non-CBSA code if a rural facility, in effect at the beginning of the cost reporting period. Enter in column 2, the code in effect on or after October 1 of the cost reporting period (if applicable).
 16974 201.00

		Expenses	Percentage	Associated with Direct Patient Care and Related Expenses?
		1.00	2.00	3.00

A notice published in the Federal Register Volume 68, No. 149 August 4, 2003 provided for an increase in the RUG payments beginning 10/01/2003. Congress expected this increase to be used for direct patient care and related expenses. For lines 202 through 207: Enter in column 1 the amount of the expense for each category. Enter in column 2 the percentage of total expenses for each category to total SNF revenue from Worksheet G-2, Part I, line 7, column 3. In column 3, enter "Y" for yes or "N" for no if the spending reflects increases associated with direct patient care and related expenses for each category. (see instructions)

202.00	Staffing	0	0.00	202.00
203.00	Recruitment	0	0.00	203.00
204.00	Retention of employees	0	0.00	204.00
205.00	Training	0	0.00	205.00
206.00	OTHER (SPECIFY)	0	0.00	206.00
207.00	Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)	10,155,910		207.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 143027

Period:
From 07/01/2012
To 06/30/2013

Worksheet A
Date/Time Prepared:
11/20/2013 11:00 am

Cost Center Description	Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
	1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS-BLDG & FIXT		2,649,082	2,649,082	0	2,649,082	1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP		656,064	656,064	0	656,064	2.00
3.00 00300 OTHER CAP REL COSTS		0	0	0	0	3.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	50,993	1,232,273	1,283,266	4,421,681	5,704,947	4.00
5.01 00510 A&G NON INTERN & NON RESIDENT	1,884,132	4,468,911	6,353,043	-767,805	5,585,238	5.01
5.02 00530 A&G PURCHASING RECEIVING AND STORES	297,395	102,528	399,923	-32,507	367,416	5.02
5.03 00540 A&G ADMITTING	1,612,516	575,241	2,187,757	-705,806	1,481,951	5.03
5.04 00550 A&G PFS - CASHIER /ACCTS RECEIVABLE	636,111	212,563	848,674	-69,442	779,232	5.04
5.05 00560 A&G OTHER A&G IR RELATED	1,542,913	7,624,855	9,167,768	-1,508,716	7,659,052	5.05
6.00 00600 MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00 00700 OPERATION OF PLANT	301,688	2,590,161	2,891,849	-1,578,510	1,313,339	7.00
8.00 00800 LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00 00900 HOUSEKEEPING	701,239	471,014	1,172,253	-60,241	1,112,012	9.00
10.00 01000 DIETARY	1,095,216	1,060,710	2,155,926	-442,213	1,713,713	10.00
11.00 01100 CAFETERIA	0	0	0	692,118	692,118	11.00
12.00 01200 MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00 01300 NURSING ADMINISTRATION	517,178	136,250	653,428	-60,761	592,667	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	161,845	70,381	232,226	35,282	267,508	14.00
15.00 01500 PHARMACY	0	0	0	0	0	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	1,003,807	583,831	1,587,638	-107,769	1,479,869	16.00
17.00 01700 SOCIAL SERVICE	0	0	0	832,345	832,345	17.00
18.00 01850 OTHER GENERAL SERVICE (SPECIFY)	74,145	17,570	91,715	-2,424	89,291	18.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	976,736	0	976,736	-60,340	916,396	21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	384,684	384,684	85,621	470,305	22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	9,456,546	3,615,398	13,071,944	740,921	13,812,865	30.00
44.00 04400 SKILLED NURSING FACILITY	1,744,319	1,085,777	2,830,096	-842,918	1,987,178	44.00
46.00 04600 OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS						
54.00 05400 RADIOLOGY-DIAGNOSTIC	91,771	74,163	165,934	237,681	403,615	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000 LABORATORY	0	337,155	337,155	426,737	763,892	60.00
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	209,580	92,157	301,737	-5,982	295,755	65.00
66.00 06600 PHYSICAL THERAPY	2,067,255	415,132	2,482,387	-172,993	2,309,394	66.00
67.00 06700 OCCUPATIONAL THERAPY	1,639,702	326,100	1,965,802	-133,706	1,832,096	67.00
68.00 06800 SPEECH PATHOLOGY	886,414	185,164	1,071,578	-85,819	985,759	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	265,176	265,176	92,524	357,700	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	977,512	571,261	1,548,773	156,786	1,705,559	73.00
74.00 07400 RENAL DIALYSIS	0	93,556	93,556	0	93,556	74.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	0	0	0	0	90.00
90.01 09001 WHEATON OUTPATIENT	1,853,112	608,778	2,461,890	-154,838	2,307,052	90.01
90.02 09002 OTHER DAY HOSPITAL	1,623,300	484,742	2,108,042	-227,940	1,880,102	90.02
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE	0	0	0	0	0	113.00
114.00 11400 UTILIZATION REVIEW-SNF	0	0	0	0	0	114.00
118.00 11800 SUBTOTALS (SUM OF LINES 1-117)	31,405,425	30,990,677	62,396,102	700,966	63,097,068	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,628	1,628	4,609	6,237	190.00
191.00 19100 RESEARCH	5,994,926	1,789,683	7,784,609	-705,575	7,079,034	191.00
200.00 20000 TOTAL (SUM OF LINES 118-199)	37,400,351	32,781,988	70,182,339	0	70,182,339	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 143027

Period:
From 07/01/2012
To 06/30/2013

Worksheet A
Date/Time Prepared:
11/20/2013 11:00 am

Cost Center Description		Adjustments (See A-8)	Net Expenses For Allocation	
		6.00	7.00	
GENERAL SERVICE COST CENTERS				
1.00	00100			1.00
		0	2,649,082	
2.00	00200			2.00
		0	656,064	
3.00	00300			3.00
		0	0	
4.00	00400			4.00
		0	5,704,947	
5.01	00510			5.01
		-989,310	4,595,928	
5.02	00530			5.02
		-1,927	365,489	
5.03	00540			5.03
		-76	1,481,875	
5.04	00550			5.04
		-8,270	770,962	
5.05	00560			5.05
		802,651	8,461,703	
6.00	00600			6.00
		0	0	
7.00	00700			7.00
		-290,901	1,022,438	
8.00	00800			8.00
		0	0	
9.00	00900			9.00
		-9	1,112,003	
10.00	01000			10.00
		-805,755	907,958	
11.00	01100			11.00
		0	692,118	
12.00	01200			12.00
		0	0	
13.00	01300			13.00
		0	592,667	
14.00	01400			14.00
		0	267,508	
15.00	01500			15.00
		0	0	
16.00	01600			16.00
		-185,705	1,294,164	
17.00	01700			17.00
		0	832,345	
18.00	01850			18.00
		0	89,291	
21.00	02100			21.00
		0	916,396	
22.00	02200			22.00
		-65,342	404,963	
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000			30.00
		-497,626	13,315,239	
44.00	04400			44.00
		0	1,987,178	
46.00	04600			46.00
		0	0	
ANCILLARY SERVICE COST CENTERS				
54.00	05400			54.00
		-500	403,115	
55.00	05500			55.00
		0	0	
58.00	05800			58.00
		0	0	
59.00	05900			59.00
		0	0	
60.00	06000			60.00
		0	763,892	
61.00	06100			61.00
		0	0	
64.00	06400			64.00
		0	0	
65.00	06500			65.00
		0	295,755	
66.00	06600			66.00
		0	2,309,394	
67.00	06700			67.00
		0	1,832,096	
68.00	06800			68.00
		0	985,759	
69.00	06900			69.00
		0	0	
71.00	07100			71.00
		0	357,700	
72.00	07200			72.00
		0	0	
73.00	07300			73.00
		-14,869	1,690,690	
74.00	07400			74.00
		0	93,556	
OUTPATIENT SERVICE COST CENTERS				
90.00	09000			90.00
		0	0	
90.01	09001			90.01
		-135,996	2,171,056	
90.02	09002			90.02
		-46,037	1,834,065	
92.00	09200			92.00
OTHER REIMBURSABLE COST CENTERS				
96.00	09600			96.00
		0	0	
100.00	10000			100.00
		0	0	
SPECIAL PURPOSE COST CENTERS				
113.00	11300			113.00
		0	0	
114.00	11400			114.00
		0	0	
118.00	11800			118.00
		-2,239,672	60,857,396	
NONREIMBURSABLE COST CENTERS				
190.00	19000			190.00
		0	6,237	
191.00	19100			191.00
		-86,234	6,992,800	
200.00	20000			200.00
		-2,325,906	67,856,433	

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - EMPLOYEE BENEFITS					
1.00	EMPLOYEE BENEFITS	4.00	0	4,425,357	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
TOTALS			0	4,425,357	
B - DIETARY					
1.00	CAFETERIA	11.00	0	692,118	1.00
TOTALS			0	692,118	
C - MEDICAL SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	43,160	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
TOTALS			0	43,160	
D - PATIENT SCHEDULING					
1.00	ADULTS & PEDIATRICS	30.00	310,053	30,184	1.00
2.00	WHEATON OUTPATIENT	90.01	63,412	6,173	2.00
TOTALS			373,465	36,357	
E - STAFF RECLASS					
1.00	SOCIAL SERVICE	17.00	832,345	0	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
TOTALS			832,345	0	
F - CROSS DEPARTMENT					
1.00	RADIOLOGY-DIAGNOSTIC	54.00	229,166	0	1.00
2.00	LABORATORY	60.00	387,457	0	2.00
3.00	RESPIRATORY THERAPY	65.00	822	0	3.00
TOTALS			617,445	0	
G - SPACE					
1.00	EMPLOYEE BENEFITS	4.00	0	7,626	1.00
2.00	A&G NON INTERN & NON RESIDENT	5.01	0	27,983	2.00
3.00	A&G PURCHASING RECEIVING AND STORES	5.02	0	2,377	3.00
4.00	A&G PFS - CASHIER /ACCTS RECEIVABLE	5.04	0	5,174	4.00
5.00	A&G OTHER A&G IR RELATED	5.05	0	65,987	5.00
6.00	OPERATION OF PLANT	7.00	0	24,870	6.00
7.00	HOUSEKEEPING	9.00	0	8,913	7.00

RECLASSIFICATIONS

Provider CCN: 143027

Period:
From 07/01/2012
To 06/30/2013

Worksheet A-6

Date/Time Prepared:
11/20/2013 11:00 am

Increases					
	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	
8.00	DIETARY	10.00	0	22,728	8.00
9.00	MEDICAL RECORDS & LIBRARY	16.00	0	9,978	9.00
10.00	I&R SERVICES-SALARY & FRINGES APPRVD	21.00	0	3,404	10.00
11.00	ADULTS & PEDIATRICS	30.00	0	17,615	11.00
12.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,634	12.00
13.00	OCCUPATIONAL THERAPY	67.00	0	433	13.00
14.00	SPEECH PATHOLOGY	68.00	0	619	14.00
15.00	WHEATON OUTPATIENT	90.01	0	68,753	15.00
16.00	RESEARCH	191.00	0	1,980	16.00
	TOTALS		0	270,074	
H - SPACE RECLASS NEW HOSPITAL					
1.00	A&G NON INTERN & NON RESIDENT	5.01		21,249	1.00
2.00	A&G ADMITTING	5.03		17,317	2.00
3.00	A&G OTHER A&G IR RELATED	5.05		24,175	3.00
4.00	OPERATION OF PLANT	7.00		119,224	4.00
5.00	HOUSEKEEPING	9.00		12,152	5.00
6.00	DIETARY	10.00		50,450	6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00		54,608	7.00
8.00	OTHER GENERAL SERVICE (SPECIFY)	18.00		6,276	8.00
9.00	ADULTS & PEDIATRICS	30.00		801,858	9.00
10.00	SKILLED NURSING FACILITY	44.00		135,412	10.00
11.00	PHYSICAL THERAPY	66.00		67,350	11.00
12.00	OCCUPATIONAL THERAPY	67.00		59,000	12.00
13.00	SPEECH PATHOLOGY	68.00		17,916	13.00
14.00	DRUGS CHARGED TO PATIENTS	73.00		25,546	14.00
15.00	GI FT, FLOWER, COFFEE SHOP & CANTEEN	190.00		4,609	15.00
	TOTALS		0	1,417,142	
I - LIBRARY					
1.00	I&R SERVICES-SALARY & FRINGES APPRVD	21.00	50,827	0	1.00
2.00	I&R SERVICES-OTHER PRGM COSTS APPRVD	22.00	0	85,621	2.00
	TOTALS		50,827	85,621	
J - SNF					
1.00	DIETARY	10.00	0	305,051	1.00
2.00	ADULTS & PEDIATRICS	30.00	0	1,045	2.00
3.00	RADIOLOGY-DIAGNOSTIC	54.00	0	17,605	3.00
4.00	LABORATORY	60.00	0	39,280	4.00
5.00	RESPIRATORY THERAPY	65.00	0	17,780	5.00
6.00	PHYSICAL THERAPY	66.00	0	2,151	6.00
7.00	RADIOLOGY-DIAGNOSTIC	54.00	0	41	7.00
8.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71.00	0	49,364	8.00
9.00	DRUGS CHARGED TO PATIENTS	73.00	0	246,096	9.00
	TOTALS		0	678,413	
K - INTEREST EXPENSE					
1.00	ADULTS & PEDIATRICS	30.00	0	1,417,894	1.00
	TOTALS		0	1,417,894	
500.00	Grand Total: Increases		1,874,082	9,066,136	500.00

RECLASSIFICATIONS

Provider CCN: 143027

Period:
From 07/01/2012
To 06/30/2013

Worksheet A-6
Date/Time Prepared:
11/20/2013 11:00 am

Decreases						
Cost Center	Line #	Salary	Other	Wkst.	A-7 Ref.	
6.00	7.00	8.00	9.00	10.00		
A - EMPLOYEE BENEFITS						
1.00	A&G NON INTERN & NON RESIDENT	5.01	0	266,521	0	1.00
2.00	A&G PURCHASING RECEIVING AND STORES	5.02	0	34,884	0	2.00
3.00	A&G ADMITTING	5.03	0	189,148	0	3.00
4.00	A&G PFS - CASHIER /ACCTS RECEIVABLE	5.04	0	74,616	0	4.00
5.00	A&G OTHER A&G IR RELATED	5.05	0	180,984	0	5.00
6.00	OPERATION OF PLANT	7.00	0	35,388	0	6.00
7.00	HOUSEKEEPING	9.00	0	81,306	0	7.00
8.00	DIETARY	10.00	0	128,324	0	8.00
9.00	NURSING ADMINISTRATION	13.00	0	60,665	0	9.00
10.00	CENTRAL SERVICES & SUPPLY	14.00	0	18,984	0	10.00
11.00	MEDICAL RECORDS & LIBRARY	16.00	0	117,747	0	11.00
12.00	OTHER GENERAL SERVICE (SPECIFY)	18.00	0	8,700	0	12.00
13.00	I&R SERVICES-SALARY & FRINGES APPRVD	21.00	0	114,571	0	13.00
14.00	ADULTS & PEDIATRICS	30.00	0	1,105,835	0	14.00
15.00	SKILLED NURSING FACILITY	44.00	0	204,660	0	15.00
16.00	RADIOLOGY-DIAGNOSTIC	54.00	0	10,765	0	16.00
17.00	RESPIRATORY THERAPY	65.00	0	24,584	0	17.00
18.00	PHYSICAL THERAPY	66.00	0	242,489	0	18.00
19.00	OCCUPATIONAL THERAPY	67.00	0	192,337	0	19.00
20.00	SPEECH PATHOLOGY	68.00	0	103,976	0	20.00
21.00	DRUGS CHARGED TO PATIENTS	73.00	0	114,655	0	21.00
22.00	A&G NON INTERN & NON RESIDENT	5.01	0	3,230	0	22.00
23.00	WHEATON OUTPATIENT	90.01	0	217,370	0	23.00
24.00	OTHER DAY HOSPITAL	90.02	0	190,413	0	24.00
25.00	RESEARCH	191.00	0	703,205	0	25.00
	TOTALS		0	4,425,357		
B - DIETARY						
1.00	DIETARY	10.00	0	692,118	0	1.00
	TOTALS		0	692,118		
C - MEDICAL SUPPLIES						
1.00	A&G ADMITTING	5.03	0	9,489	0	1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	342	0	2.00
3.00	ADULTS & PEDIATRICS	30.00	0	22,915	0	3.00
4.00	SKILLED NURSING FACILITY	44.00	0	624	0	4.00
5.00	PHYSICAL THERAPY	66.00	0	5	0	5.00
6.00	OCCUPATIONAL THERAPY	67.00	0	802	0	6.00
7.00	SPEECH PATHOLOGY	68.00	0	378	0	7.00
8.00	DRUGS CHARGED TO PATIENTS	73.00	0	201	0	8.00
9.00	WHEATON OUTPATIENT	90.01	0	3,883	0	9.00
10.00	OTHER DAY HOSPITAL	90.02	0	171	0	10.00
11.00	RESEARCH	191.00	0	4,350	0	11.00
	TOTALS		0	43,160		
D - PATIENT SCHEDULING						
1.00	A&G NON INTERN & NON RESIDENT	5.01	373,465	36,357	0	1.00
2.00		0.00	0	0	0	2.00
	TOTALS		373,465	36,357		
E - STAFF RECLASS						
1.00	EMPLOYEE BENEFITS	4.00	11,302	0	0	1.00
2.00	A&G NON INTERN & NON RESIDENT	5.01	1,016	0	0	2.00
3.00	A&G ADMITTING	5.03	524,486	0	0	3.00
4.00	NURSING ADMINISTRATION	13.00	96	0	0	4.00
5.00	ADULTS & PEDIATRICS	30.00	91,533	0	0	5.00
6.00	SKILLED NURSING FACILITY	44.00	94,633	0	0	6.00
7.00	WHEATON OUTPATIENT	90.01	71,923	0	0	7.00
8.00	OTHER DAY HOSPITAL	90.02	37,356	0	0	8.00
	TOTALS		832,345	0		
F - CROSS DEPARTMENT						
1.00	ADULTS & PEDIATRICS	30.00	617,445	0	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00
	TOTALS		617,445	0		
G - SPACE						
1.00	OPERATION OF PLANT	7.00	0	270,074	0	1.00
2.00		0.00	0	0	0	2.00
3.00		0.00	0	0	0	3.00

Decreases							
Cost Center	Line #	Salary	Other	Wkst. A-7	Ref.		
6.00	7.00	8.00	9.00	10.00			
4.00	0.00	0	0	0	0		4.00
5.00	0.00	0	0	0	0		5.00
6.00	0.00	0	0	0	0		6.00
7.00	0.00	0	0	0	0		7.00
8.00	0.00	0	0	0	0		8.00
9.00	0.00	0	0	0	0		9.00
10.00	0.00	0	0	0	0		10.00
11.00	0.00	0	0	0	0		11.00
12.00	0.00	0	0	0	0		12.00
13.00	0.00	0	0	0	0		13.00
14.00	0.00	0	0	0	0		14.00
15.00	0.00	0	0	0	0		15.00
16.00	0.00	0	0	0	0		16.00
TOTALS		0	270,074				
H - SPACE RECLASS NEW HOSPITAL							
1.00	OPERATION OF PLANT	7.00	0	1,417,142	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
TOTALS		0	1,417,142				
I - LIBRARY							
1.00	A&G NON INTERN & NON RESIDENT	5.01	50,827	85,621	0		1.00
2.00		0.00	0	0	0		2.00
TOTALS			50,827	85,621			
J - SNF							
1.00	SKILLED NURSING FACILITY	44.00	0	678,413	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
TOTALS			0	678,413			
K - INTEREST EXPENSE							
1.00	A&G OTHER A&G IR RELATED	5.05	0	1,417,894	0		1.00
TOTALS			0	1,417,894			
500.00	Grand Total: Decreases		1,874,082	9,066,136			500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 143027

Period:
From 07/01/2012
To 06/30/2013

Worksheet A-7
Part I
Date/Time Prepared:
11/20/2013 11:00 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	887,110	212,964	0	212,964	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	78,135,690	956,891	0	956,891	0	3.00
4.00	Building Improvements	0	0	0	0	0	4.00
5.00	Fixed Equipment	0	0	0	0	0	5.00
6.00	Movable Equipment	9,997,442	523,890	0	523,890	202,682	6.00
7.00	HIT designated Assets	0	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	89,020,242	1,693,745	0	1,693,745	202,682	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	89,020,242	1,693,745	0	1,693,745	202,682	10.00
		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	1,100,074	0				1.00
2.00	Land Improvements	0	0				2.00
3.00	Buildings and Fixtures	79,092,581	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	10,318,650	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	90,511,305	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	90,511,305	0				10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 143027

Period:
From 07/01/2012
To 06/30/2013

Worksheet A-7
Part II
Date/Time Prepared:
11/20/2013 11:00 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	2,649,082	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	656,064	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	3,305,146	0	0	0	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Other Capital-Related Costs (see instructions)	Total (1) (sum of cols. 9 through 14)				
		14.00	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	0	2,649,082				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	656,064				2.00
3.00	Total (sum of lines 1-2)	0	3,305,146				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS		Provider CCN: 143027	Period: From 07/01/2012 To 06/30/2013	Worksheet A-7 Part III Date/Time Prepared: 11/20/2013 11:00 am
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Cost Center Description		COMPUTATION OF RATIOS			ALLOCATION OF OTHER CAPITAL		
		Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	80,192,655	0	80,192,655	0.885996	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	10,318,650	0	10,318,650	0.114004	0	2.00
3.00	Total (sum of lines 1-2)	90,511,305	0	90,511,305	1.000000	0	3.00
Cost Center Description		ALLOCATION OF OTHER CAPITAL			SUMMARY OF CAPITAL		
		Taxes	Other Capital-Related Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
		6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	2,649,082	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	656,064	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	3,305,146	0	3.00
Cost Center Description		SUMMARY OF CAPITAL					
		Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
		11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	0	2,649,082	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	656,064	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	3,305,146	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 143027

Period:
From 07/01/2012
To 06/30/2013

Worksheet A-8

Date/Time Prepared:
11/20/2013 11:00 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted				
			Cost Center	Line #	Wkst. A-7 Ref.		
			1.00	2.00	3.00	4.00	5.00
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			0	CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00 Investment income - other (chapter 2)			0		0.00	0	3.00
4.00 Trade, quantity, and time discounts (chapter 8)			0		0.00	0	4.00
5.00 Refunds and rebates of expenses (chapter 8)			0		0.00	0	5.00
6.00 Rental of provider space by suppliers (chapter 8)			0		0.00	0	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)			0		0.00	0	7.00
8.00 Television and radio service (chapter 21)			0		0.00	0	8.00
9.00 Parking lot (chapter 21)			0		0.00	0	9.00
10.00 Provider-based physician adjustment	A-8-2	-444,425				0	10.00
11.00 Sale of scrap, waste, etc. (chapter 23)			0		0.00	0	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	2,853,256				0	12.00
13.00 Laundry and linen service			0		0.00	0	13.00
14.00 Cafeteria-employees and guests	B	-748,937		DIETARY	10.00	0	14.00
15.00 Rental of quarters to employee and others			0		0.00	0	15.00
16.00 Sale of medical and surgical supplies to other than patients	B	-5,179		MEDICAL RECORDS & LIBRARY	16.00	0	16.00
17.00 Sale of drugs to other than patients			0		0.00	0	17.00
18.00 Sale of medical records and abstracts	B	-180,526		MEDICAL RECORDS & LIBRARY	16.00	0	18.00
19.00 Nursing school (tuition, fees, books, etc.)			0		0.00	0	19.00
20.00 Vending machines			0		0.00	0	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)			0		0.00	0	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0		0.00	0	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3			RESPIRATORY THERAPY	65.00		23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3			PHYSICAL THERAPY	66.00		24.00
25.00 Utilization review - physicians' compensation (chapter 21)				UTILIZATION REVIEW-SNF	114.00		25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT			0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00 Non-physician Anesthetist			0	*** Cost Center Deleted ***	19.00		28.00
29.00 Physicians' assistant			0		0.00	0	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3			OCCUPATIONAL THERAPY	67.00		30.00
30.99 Hospice (non-distinct) (see instructions)				ADULTS & PEDIATRICS	30.00		30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3			SPEECH PATHOLOGY	68.00		31.00
32.00 CAH HIT Adjustment for Depreciation and Interest			0		0.00	0	32.00
33.00 TRANSPORTATION EXPENSE	A	-9		HOUSEKEEPING	9.00	0	33.00
33.01			0		0.00	0	33.01

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			Wkst. A-7 Ref.
			Cost Center	Line #		
			1.00	2.00	3.00	
33.02 OPERATING REVENUE	B	-104,105	A&G NON INTERN & NON RESIDENT	5.01	0	33.02
33.03 OPERATING REVENUE	B	-8,270	A&G PFS - CASHIER /ACCTS RECEIVABLE	5.04	0	33.03
33.04 OPERATING REVENUE	B	-1,786,097	A&G OTHER A&G IR RELATED	5.05	0	33.04
33.05 OPERATING REVENUE	B	-168,235	OPERATION OF PLANT	7.00	0	33.05
33.06 OPERATING REVENUE	B	-65,342	I&R SERVICES-OTHER PRGM COSTS APPRVD	22.00	0	33.06
33.07 OPERATING REVENUE	B	-15,040	ADULTS & PEDIATRICS	30.00	0	33.07
33.08 OPERATING REVENUE	B	-10,844	WHEATON OUTPATIENT	90.01	0	33.08
33.09 OPERATING REVENUE	B	0		0.00	0	33.09
33.10 OPERATING REVENUE / REFUNDS	B	-1,927	A&G PURCHASING RECEIVING AND STORES	5.02	0	33.10
33.11 OPERATING REVENUE / REFUNDS	B	-56,818	DIETARY	10.00	0	33.11
33.12 OPERATING REVENUE / REFUNDS	B	-14,869	DRUGS CHARGED TO PATIENTS	73.00	0	33.12
33.13 OPERATING REVENUE / REFUNDS	B	-725	OPERATION OF PLANT	7.00	0	33.13
34.00 TRANSPORTATION EXPENSE	A	-38,661	ADULTS & PEDIATRICS	30.00	0	34.00
34.01 TRANSPORTATION EXPENSE	A	-125,152	WHEATON OUTPATIENT	90.01	0	34.01
34.02 TRANSPORTATION EXPENSE	A	-46,037	OTHER DAY HOSPITAL	90.02	0	34.02
34.03 TRANSPORTATION EXPENSE	A	-71,285	RESEARCH	191.00	0	34.03
34.04 TRANSPORTATION EXPENSE	A	-76	A&G ADMITTING	5.03	0	34.04
34.05 TRANSPORTATION EXPENSE	A	-508,415	A&G NON INTERN & NON RESIDENT	5.01	0	34.05
35.00 FUNDRAISING	A	-272,685	A&G NON INTERN & NON RESIDENT	5.01	0	35.00
36.00 MARKETING	A	-258,757	A&G OTHER A&G IR RELATED	5.05	0	36.00
37.00		0		0.00	0	37.00
38.00 RMC LEASE	A	-121,941	OPERATION OF PLANT	7.00	0	38.00
39.00 OTHER NONALLOWABLE COST	A	-5,751	A&G OTHER A&G IR RELATED	5.05	0	39.00
40.00 OAKBROOK TERRACE LEASE	A	-104,105	A&G NON INTERN & NON RESIDENT	5.01	0	40.00
41.00 OTHER NONALLOWABLE COST	A	-14,949	RESEARCH	191.00	0	41.00
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-2,325,906				50.00

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

Provider CCN: 143027

Period: From 07/01/2012 To 06/30/2013

Worksheet A-8-1

Date/Time Prepared: 11/20/2013 11:00 am

Line No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount Included in Wks. A, column 5	
1.00	2.00	3.00	4.00	5.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	7.00	OPERATION OF PLANT	OLA LEASE - RENT	6,474	6,474 1.00
2.00	5.05	A&G OTHER A&G IR RELATED	HOME OFFICE ASSESSMENT	17,649,237	14,876,942 2.00
3.00	5.05	A&G OTHER A&G IR RELATED	WFSI SE WISCONSIN	278,724	197,763 3.00
4.00	0.00			0	0 4.00
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			17,934,435	15,081,179 5.00

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

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

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

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

6.00	B	OLA	0.00	OLA	0.00	6.00
7.00	B	WFH	0.00	WFH	0.00	7.00
8.00	B	WFH SE WI	0.00	WFH SE WI	0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:					100.00

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

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

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

Provider CCN: 143027

Period:
From 07/01/2012
To 06/30/2013

Worksheet A-8-1

Date/Time Prepared:
11/20/2013 11:00 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	0	0		1.00
2.00	2,772,295	0		2.00
3.00	80,961	0		3.00
4.00	0	0		4.00
5.00	2,853,256			5.00

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

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

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

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

6.00	MOTHER HOUSE		6.00
7.00	CORPORATE OFFICE		7.00
8.00	LAUNDRY SERVICE		8.00
9.00			9.00
10.00			10.00
100.00			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 143027

Period:
From 07/01/2012
To 06/30/2013

Worksheet A-8-2

Date/Time Prepared:
11/20/2013 11:00 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	30.00	ADULTS & PEDIATRICS	60,000	0	60,000	177,200	400	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	500	0	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	817,128	0	717,128	177,200	4,685	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			877,628	0	777,128		5,085	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	30.00	ADULTS & PEDIATRICS	34,077	1,704	0	0	0	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	2.00
3.00	30.00	ADULTS & PEDIATRICS	399,126	19,956	0	0	0	3.00
4.00	0.00		0	0	0	0	0	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			433,203	21,660	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	30.00	ADULTS & PEDIATRICS	0	34,077	25,923	25,923	1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	0	0	0	500	2.00
3.00	30.00	ADULTS & PEDIATRICS	0	399,126	318,002	418,002	3.00
4.00	0.00		0	0	0	0	4.00
5.00	0.00		0	0	0	0	5.00
6.00	0.00		0	0	0	0	6.00
7.00	0.00		0	0	0	0	7.00
8.00	0.00		0	0	0	0	8.00
9.00	0.00		0	0	0	0	9.00
10.00	0.00		0	0	0	0	10.00
200.00			0	433,203	343,925	444,425	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 143027

Period:
From 07/01/2012
To 06/30/2013

Worksheet B
Part I
Date/Time Prepared:
11/20/2013 11:00 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	A&G NON INTERN & NON RESIDENT	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	5.01	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	2,649,082	2,649,082			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	656,064		656,064		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	5,704,947	0	0	5,704,947	4.00
5.01 00510	A&G NON INTERN & NON RESIDENT	4,595,928	39,722	44,125	222,761	4,902,536
5.02 00530	A&G PURCHASING RECEIVING AND STORES	365,489	0	930	45,412	0
5.03 00540	A&G ADMITTING	1,481,875	32,371	1,317	166,141	0
5.04 00550	A&G PFS - CASHIER /ACCTS RECEIVABLE	770,962	0	2,259	97,134	0
5.05 00560	A&G OTHER A&G IR RELATED	8,461,703	45,190	34,079	235,601	0
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	0
7.00 00700	OPERATION OF PLANT	1,022,438	222,866	198,915	46,067	0
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0
9.00 00900	HOUSEKEEPING	1,112,003	22,717	7,232	107,078	0
10.00 01000	DIETARY	907,958	94,306	19,326	167,238	0
11.00 01100	CAFETERIA	692,118	0	0	0	0
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00 01300	NURSING ADMINISTRATION	592,667	0	358	78,958	0
14.00 01400	CENTRAL SERVICES & SUPPLY	267,508	102,079	13,616	24,714	0
15.00 01500	PHARMACY	0	0	0	0	0
16.00 01600	MEDICAL RECORDS & LIBRARY	1,294,164	0	3,963	153,280	0
17.00 01700	SOCIAL SERVICE	832,345	0	0	127,098	0
18.00 01850	OTHER GENERAL SERVICE (SPECIFY)	89,291	11,732	762	11,322	0
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	916,396	0	328	156,908	0
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	404,963	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	13,315,239	1,498,922	127,562	1,383,102	1,779,969
44.00 04400	SKILLED NURSING FACILITY	1,987,178	253,128	1,301	251,905	683,929
46.00 04600	OTHER LONG TERM CARE	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS						
54.00 05400	RADIOLOGY-DIAGNOSTIC	403,115	0	20,998	49,007	81,582
55.00 05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00 06000	LABORATORY	763,892	0	0	59,164	164,879
61.00 06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00 06500	RESPIRATORY THERAPY	295,755	0	2,174	32,128	116,483
66.00 06600	PHYSICAL THERAPY	2,309,394	125,899	8,170	315,668	592,621
67.00 06700	OCCUPATIONAL THERAPY	1,832,096	110,289	1,084	250,381	559,586
68.00 06800	SPEECH PATHOLOGY	985,759	33,491	4,285	135,355	473,240
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	0
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	357,700	0	0	0	135,213
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00 07300	DRUGS CHARGED TO PATIENTS	1,690,690	47,754	8,302	149,265	301,959
74.00 07400	RENAL DIALYSIS	93,556	0	0	0	13,075
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	0
90.01 09001	WHEATON OUTPATIENT	2,171,056	0	36,435	281,669	0
90.02 09002	OTHER DAY HOSPITAL	1,834,065	0	19,464	242,172	0
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS						
96.00 09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0
100.00 10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE	0	0	0	0	0
114.00 11400	UTILIZATION REVIEW-SNF	0	0	0	0	0
118.00	SUBTOTALS (SUM OF LINES 1-117)	60,857,396	2,640,466	556,985	4,789,528	4,902,536
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	6,237	8,616	0	0	0
191.00 19100	RESEARCH	6,992,800	0	99,079	915,419	0
200.00	Cross Foot Adjustments	0	0	0	0	0
201.00	Negative Cost Centers	0	0	0	0	0
202.00	TOTAL (sum lines 118-201)	67,856,433	2,649,082	656,064	5,704,947	4,902,536

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 143027

Period:
From 07/01/2012
To 06/30/2013

Worksheet B
Part I
Date/Time Prepared:
11/20/2013 11:00 am

Cost Center Description		A&G PURCHASING RECEIVING AND STORES	A&G ADMINITING	A&G PFS - CASHIER /ACCTS RECEIVABLE	Subtotal	A&G OTHER A&G IR RELATED		
		5.02	5.03	5.04	5A.04	5.05		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00	
5.01	00510	A&G NON INTERN & NON RESIDENT					5.01	
5.02	00530	A&G PURCHASING RECEIVING AND STORES	411,831				5.02	
5.03	00540	A&G ADMINITING	6,362	1,688,066			5.03	
5.04	00550	A&G PFS - CASHIER /ACCTS RECEIVABLE	1,048	0	871,403		5.04	
5.05	00560	A&G OTHER A&G IR RELATED	14,094	0	0	8,790,667	5.05	
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00	
7.00	00700	OPERATION OF PLANT	37,897	0	0	1,528,183	227,436	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	48,921	0	0	1,297,951	193,171	9.00
10.00	01000	DIETARY	6,249	0	0	1,195,077	177,861	10.00
11.00	01100	CAFETERIA	0	0	0	692,118	103,007	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	403	0	0	672,386	100,070	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	20,407	0	0	428,324	63,747	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	4,176	0	0	1,455,583	216,632	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	959,443	142,792	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	113,107	16,833	18.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	4,454	0	0	1,078,086	160,449	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	404,963	60,270	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	73,067	508,847	262,650	18,949,358	2,820,221	30.00
44.00	04400	SKILLED NURSING FACILITY	3,569	195,511	100,929	3,477,450	517,542	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,606	23,967	12,373	597,648	88,947	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	292	47,133	24,332	1,059,692	157,712	60.00
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	7,753	33,412	17,248	504,953	75,151	65.00
66.00	06600	PHYSICAL THERAPY	6,335	172,135	88,862	3,619,084	538,621	66.00
67.00	06700	OCCUPATIONAL THERAPY	2,558	160,118	82,658	2,998,770	446,301	67.00
68.00	06800	SPEECH PATHOLOGY	3,998	136,206	70,314	1,842,648	274,238	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	66,107	38,653	19,954	617,627	91,920	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,129	86,319	44,561	2,329,979	346,766	73.00
74.00	07400	RENAL DIALYSIS	185	3,738	1,930	112,484	16,741	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WHEATON OUTPATIENT	8,181	174,854	90,266	2,762,461	411,132	90.01
90.02	09002	OTHER DAY HOSPITAL	16,600	107,173	55,326	2,274,800	338,554	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	340,391	1,688,066	871,403	59,762,842	7,586,114	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	14,853	2,211	190.00
191.00	19100	RESEARCH	71,440	0	0	8,078,738	1,202,342	191.00
200.00		Cross Foot Adjustments				0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	411,831	1,688,066	871,403	67,856,433	8,790,667	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 143027

Period:
From 07/01/2012
To 06/30/2013

Worksheet B
Part I
Date/Time Prepared:
11/20/2013 11:00 am

Cost Center Description		MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00510	A&G NON INTERN & NON RESIDENT					5.01
5.02	00530	A&G PURCHASING RECEIVING AND STORES					5.02
5.03	00540	A&G ADMITTING					5.03
5.04	00550	A&G PFS - CASHIER /ACCTS RECEIVABLE					5.04
5.05	00560	A&G OTHER A&G IR RELATED					5.05
6.00	00600	MAINTENANCE & REPAIRS	0				6.00
7.00	00700	OPERATION OF PLANT	0	1,755,619			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0		8.00
9.00	00900	HOUSEKEEPING	0	17,273	0	1,508,395	9.00
10.00	01000	DIETARY	0	71,707	0	62,221	1,506,866
11.00	01100	CAFETERIA	0	0	0	0	0
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	0
14.00	01400	CENTRAL SERVICES & SUPPLY	0	77,617	0	67,349	0
15.00	01500	PHARMACY	0	0	0	0	0
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	0
17.00	01700	SOCIAL SERVICE	0	0	0	0	0
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	8,920	0	7,740	0
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	1,139,721	0	988,958	1,225,495
44.00	04400	SKILLED NURSING FACILITY	0	192,468	0	167,008	281,371
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	0	0	0	0	0
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0
66.00	06600	PHYSICAL THERAPY	0	95,728	0	83,065	0
67.00	06700	OCCUPATIONAL THERAPY	0	83,859	0	72,766	0
68.00	06800	SPEECH PATHOLOGY	0	25,465	0	22,096	0
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	36,310	0	31,507	0
74.00	07400	RENAL DIALYSIS	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0
90.01	09001	WHEATON OUTPATIENT	0	0	0	0	0
90.02	09002	OTHER DAY HOSPITAL	0	0	0	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	1,749,068	0	1,502,710	1,506,866
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	6,551	0	5,685	0
191.00	19100	RESEARCH	0	0	0	0	0
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	0	1,755,619	0	1,508,395	1,506,866

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 143027

Period:
From 07/01/2012
To 06/30/2013

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Part I
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Cost Center Description		CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		11.00	12.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00510						5.01
5.02	00530						5.02
5.03	00540						5.03
5.04	00550						5.04
5.05	00560						5.05
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	795,125					11.00
12.00	01200		0				12.00
13.00	01300		0	772,456			13.00
14.00	01400		0	0	637,037		14.00
15.00	01500		0	0	0	0	15.00
16.00	01600		0	0	4,678	0	16.00
17.00	01700		0	0	0	0	17.00
18.00	01850		0	0	0	0	18.00
21.00	02100		0	0	487	0	21.00
22.00	02200		0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	795,125	0	772,456	396,956	0	30.00
44.00	04400		0	0	13,889	0	44.00
46.00	04600		0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400		0	0	115	0	54.00
55.00	05500		0	0	0	0	55.00
58.00	05800		0	0	0	0	58.00
59.00	05900		0	0	0	0	59.00
60.00	06000		0	0	191	0	60.00
61.00	06100		0	0	0	0	61.00
64.00	06400		0	0	0	0	64.00
65.00	06500		0	0	96	0	65.00
66.00	06600		0	0	4,870	0	66.00
67.00	06700		0	0	3,187	0	67.00
68.00	06800		0	0	1,299	0	68.00
69.00	06900		0	0	0	0	69.00
71.00	07100		0	0	197,420	0	71.00
72.00	07200		0	0	0	0	72.00
73.00	07300		0	0	5,080	0	73.00
74.00	07400		0	0	777	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000		0	0	0	0	90.00
90.01	09001		0	0	922	0	90.01
90.02	09002		0	0	6,823	0	90.02
92.00	09200		0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
96.00	09600		0	0	0	0	96.00
100.00	10000		0	0	0	0	100.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
114.00	11400						114.00
118.00		795,125	0	772,456	636,790	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000		0	0	0	0	190.00
191.00	19100		0	0	247	0	191.00
200.00							200.00
201.00			0	0	0	0	201.00
202.00		795,125	0	772,456	637,037	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 143027

Period:
From 07/01/2012
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Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE	INTERNS & RESIDENTS		
			(SPECIFY)	SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS	
	16.00	17.00	18.00	21.00	22.00	
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01 00510 A&G NON INTERN & NON RESIDENT						5.01
5.02 00530 A&G PURCHASING RECEIVING AND STORES						5.02
5.03 00540 A&G ADMITTING						5.03
5.04 00550 A&G PFS - CASHIER /ACCTS RECEIVABLE						5.04
5.05 00560 A&G OTHER A&G IR RELATED						5.05
6.00 00600 MAINTENANCE & REPAIRS						6.00
7.00 00700 OPERATION OF PLANT						7.00
8.00 00800 LAUNDRY & LINEN SERVICE						8.00
9.00 00900 HOUSEKEEPING						9.00
10.00 01000 DIETARY						10.00
11.00 01100 CAFETERIA						11.00
12.00 01200 MAINTENANCE OF PERSONNEL						12.00
13.00 01300 NURSING ADMINISTRATION						13.00
14.00 01400 CENTRAL SERVICES & SUPPLY						14.00
15.00 01500 PHARMACY						15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	1,676,893					16.00
17.00 01700 SOCIAL SERVICE	0	1,102,235				17.00
18.00 01850 OTHER GENERAL SERVICE (SPECIFY)	0	0	146,600			18.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	1,239,022		21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	465,233	22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	505,453	1,102,235	146,600	1,239,022	465,233	30.00
44.00 04400 SKILLED NURSING FACILITY	194,222	0	0	0	0	44.00
46.00 04600 OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS						
54.00 05400 RADIOLOGY-DIAGNOSTIC	23,809	0	0	0	0	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00 06000 LABORATORY	46,822	0	0	0	0	60.00
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	33,191	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	171,000	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	159,061	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	135,308	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	38,398	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	85,750	0	0	0	0	73.00
74.00 07400 RENAL DIALYSIS	3,713	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	0	0	0	0	90.00
90.01 09001 WHEATON OUTPATIENT	173,701	0	0	0	0	90.01
90.02 09002 OTHER DAY HOSPITAL	106,465	0	0	0	0	90.02
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTILIZATION REVIEW-SNF						114.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	1,676,893	1,102,235	146,600	1,239,022	465,233	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00 19100 RESEARCH	0	0	0	0	0	191.00
200.00 Cross Foot Adjustments				0	0	200.00
201.00 Negative Cost Centers	0	0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	1,676,893	1,102,235	146,600	1,239,022	465,233	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 143027

Period:
From 07/01/2012
To 06/30/2013

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Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00510	A&G NON INTERN & NON RESIDENT				5.01
5.02	00530	A&G PURCHASING RECEIVING AND STORES				5.02
5.03	00540	A&G ADMITTING				5.03
5.04	00550	A&G PFS - CASHIER /ACCTS RECEIVABLE				5.04
5.05	00560	A&G OTHER A&G IR RELATED				5.05
6.00	00600	MAINTENANCE & REPAIRS				6.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
12.00	01200	MAINTENANCE OF PERSONNEL				12.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)				18.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD				22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	30,546,833	-1,704,255	28,842,578	30.00
44.00	04400	SKILLED NURSING FACILITY	4,843,950	0	4,843,950	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	710,519	0	710,519	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	55.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000	LABORATORY	1,264,417	0	1,264,417	60.00
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	61.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	613,391	0	613,391	65.00
66.00	06600	PHYSICAL THERAPY	4,512,368	0	4,512,368	66.00
67.00	06700	OCCUPATIONAL THERAPY	3,763,944	0	3,763,944	67.00
68.00	06800	SPEECH PATHOLOGY	2,301,054	0	2,301,054	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	945,365	0	945,365	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,835,392	0	2,835,392	73.00
74.00	07400	RENAL DIALYSIS	133,715	0	133,715	74.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	90.00
90.01	09001	WHEATON OUTPATIENT	3,348,216	0	3,348,216	90.01
90.02	09002	OTHER DAY HOSPITAL	2,726,642	0	2,726,642	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	96.00
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	100.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
114.00	11400	UTILIZATION REVIEW-SNF				114.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	58,545,806	-1,704,255	56,841,551	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	29,300	0	29,300	190.00
191.00	19100	RESEARCH	9,281,327	0	9,281,327	191.00
200.00		Cross Foot Adjustments	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	67,856,433	-1,704,255	66,152,178	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 143027

Period: From 07/01/2012 To 06/30/2013

Worksheet B Part II Date/Time Prepared: 11/20/2013 11:00 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		0	1.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	7,626	0	0	7,626	4.00
5.01 00510	A&G NON INTERN & NON RESIDENT	27,983	39,722	44,125	111,830	5.01
5.02 00530	A&G PURCHASING RECEIVING AND STORES	2,377	0	930	3,307	5.02
5.03 00540	A&G ADMITTING	0	32,371	1,317	33,688	5.03
5.04 00550	A&G PFS - CASHIER /ACCTS RECEIVABLE	5,174	0	2,259	7,433	5.04
5.05 00560	A&G OTHER A&G IR RELATED	65,987	45,190	34,079	145,256	5.05
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	6.00
7.00 00700	OPERATION OF PLANT	24,870	222,866	198,915	446,651	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00 00900	HOUSEKEEPING	8,913	22,717	7,232	38,862	9.00
10.00 01000	DIETARY	22,728	94,306	19,326	136,360	10.00
11.00 01100	CAFETERIA	0	0	0	0	11.00
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00 01300	NURSING ADMINISTRATION	0	0	358	358	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	102,079	13,616	115,695	14.00
15.00 01500	PHARMACY	0	0	0	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	9,978	0	3,963	13,941	16.00
17.00 01700	SOCIAL SERVICE	0	0	0	0	17.00
18.00 01850	OTHER GENERAL SERVICE (SPECIFY)	0	11,732	762	12,494	18.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	3,404	0	328	3,732	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	17,615	1,498,922	127,562	1,644,099	30.00
44.00 04400	SKILLED NURSING FACILITY	0	253,128	1,301	254,429	44.00
46.00 04600	OTHER LONG TERM CARE	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS						
54.00 05400	RADIOLOGY-DIAGNOSTIC	1,634	0	20,998	22,632	54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00 06000	LABORATORY	0	0	0	0	60.00
61.00 06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	61.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	0	0	2,174	2,174	65.00
66.00 06600	PHYSICAL THERAPY	0	125,899	8,170	134,069	66.00
67.00 06700	OCCUPATIONAL THERAPY	433	110,289	1,084	111,806	67.00
68.00 06800	SPEECH PATHOLOGY	619	33,491	4,285	38,395	68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	47,754	8,302	56,056	73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	90.00
90.01 09001	WHEATON OUTPATIENT	0	0	36,435	36,435	90.01
90.02 09002	OTHER DAY HOSPITAL	68,753	0	19,464	88,217	90.02
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
96.00 09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	96.00
100.00 10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	100.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
114.00 11400	UTILIZATION REVIEW-SNF					114.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	268,094	2,640,466	556,985	3,465,545	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	8,616	0	8,616	190.00
191.00 19100	RESEARCH	1,981	0	99,079	101,060	191.00
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers				0	201.00
202.00	TOTAL (sum lines 118-201)	270,075	2,649,082	656,064	3,575,221	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 143027

Period:
From 07/01/2012
To 06/30/2013

Worksheet B
Part II
Date/Time Prepared:
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Cost Center Description		A&G NON INTERN & NON RESIDENT	A&G PURCHASING RECEIVING AND STORES	A&G ADMITTING	A&G PFS - CASHIER /ACCTS RECEIVABLE	A&G OTHER A&G IR RELATED	
		5.01	5.02	5.03	5.04	5.05	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00510	112,128					5.01
5.02	00530	0	3,368				5.02
5.03	00540	0	52	33,962			5.03
5.04	00550	0	9	0	7,572		5.04
5.05	00560	0	115	0	0	145,686	5.05
6.00	00600	0	0	0	0	0	6.00
7.00	00700	0	310	0	0	3,770	7.00
8.00	00800	0	0	0	0	0	8.00
9.00	00900	0	400	0	0	3,202	9.00
10.00	01000	0	51	0	0	2,948	10.00
11.00	01100	0	0	0	0	1,707	11.00
12.00	01200	0	0	0	0	0	12.00
13.00	01300	0	3	0	0	1,659	13.00
14.00	01400	0	167	0	0	1,057	14.00
15.00	01500	0	0	0	0	0	15.00
16.00	01600	0	34	0	0	3,591	16.00
17.00	01700	0	0	0	0	2,367	17.00
18.00	01850	0	0	0	0	279	18.00
21.00	02100	0	36	0	0	2,660	21.00
22.00	02200	0	0	0	0	999	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	40,721	598	10,257	2,304	46,719	30.00
44.00	04400	15,640	29	3,930	873	8,579	44.00
46.00	04600	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	1,866	54	482	107	1,474	54.00
55.00	05500	0	0	0	0	0	55.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	3,770	2	948	211	2,614	60.00
61.00	06100	0	0	0	0	0	61.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	2,664	63	672	149	1,246	65.00
66.00	06600	13,552	52	3,460	769	8,928	66.00
67.00	06700	12,797	21	3,219	715	7,398	67.00
68.00	06800	10,822	33	2,738	608	4,546	68.00
69.00	06900	0	0	0	0	0	69.00
71.00	07100	3,092	541	777	173	1,524	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	6,905	9	1,735	386	5,748	73.00
74.00	07400	299	2	75	17	277	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
90.01	09001	0	67	3,515	781	6,815	90.01
90.02	09002	0	136	2,154	479	5,612	90.02
92.00	09200	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
96.00	09600	0	0	0	0	0	96.00
100.00	10000	0	0	0	0	0	100.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
114.00	11400						114.00
118.00		112,128	2,784	33,962	7,572	125,719	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	37	190.00
191.00	19100	0	584	0	0	19,930	191.00
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		112,128	3,368	33,962	7,572	145,686	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 143027

Period:
From 07/01/2012
To 06/30/2013

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Part II
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Cost Center Description		MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01	00510	A&G NON INTERN & NON RESIDENT					5.01
5.02	00530	A&G PURCHASING RECEIVING AND STORES					5.02
5.03	00540	A&G ADMITTING					5.03
5.04	00550	A&G PFS - CASHIER /ACCTS RECEIVABLE					5.04
5.05	00560	A&G OTHER A&G IR RELATED					5.05
6.00	00600	MAINTENANCE & REPAIRS	0				6.00
7.00	00700	OPERATION OF PLANT	0	450,793			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0		8.00
9.00	00900	HOUSEKEEPING	0	4,435	0	47,042	9.00
10.00	01000	DIETARY	0	18,412	0	1,940	10.00
11.00	01100	CAFETERIA	0	0	0	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	19,930	0	2,100	14.00
15.00	01500	PHARMACY	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	2,290	0	241	18.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	292,649	0	30,844	130,070
44.00	04400	SKILLED NURSING FACILITY	0	49,420	0	5,208	29,864
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	0	0	0	0	0
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0
66.00	06600	PHYSICAL THERAPY	0	24,580	0	2,591	0
67.00	06700	OCCUPATIONAL THERAPY	0	21,533	0	2,269	0
68.00	06800	SPEECH PATHOLOGY	0	6,539	0	689	0
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	9,323	0	983	0
74.00	07400	RENAL DIALYSIS	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	0
90.01	09001	WHEATON OUTPATIENT	0	0	0	0	0
90.02	09002	OTHER DAY HOSPITAL	0	0	0	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	449,111	0	46,865	159,934
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1,682	0	177	0
191.00	19100	RESEARCH	0	0	0	0	0
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	0	450,793	0	47,042	159,934

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 143027

Period:
From 07/01/2012
To 06/30/2013

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Cost Center Description		CAFETERIA	MAINTENANCE OF PERSONNEL	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		11.00	12.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00510						5.01
5.02	00530						5.02
5.03	00540						5.03
5.04	00550						5.04
5.05	00560						5.05
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	1,707					11.00
12.00	01200	0	0				12.00
13.00	01300	0	0	2,125			13.00
14.00	01400	0	0	0	138,982		14.00
15.00	01500	0	0	0	0	0	15.00
16.00	01600	0	0	0	1,020	0	16.00
17.00	01700	0	0	0	0	0	17.00
18.00	01850	0	0	0	0	0	18.00
21.00	02100	0	0	0	106	0	21.00
22.00	02200	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	1,707	0	2,125	86,606	0	30.00
44.00	04400	0	0	0	3,030	0	44.00
46.00	04600	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	0	0	0	25	0	54.00
55.00	05500	0	0	0	0	0	55.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	0	0	0	42	0	60.00
61.00	06100	0	0	0	0	0	61.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	0	0	0	21	0	65.00
66.00	06600	0	0	0	1,062	0	66.00
67.00	06700	0	0	0	695	0	67.00
68.00	06800	0	0	0	283	0	68.00
69.00	06900	0	0	0	0	0	69.00
71.00	07100	0	0	0	43,071	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	1,108	0	73.00
74.00	07400	0	0	0	169	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
90.01	09001	0	0	0	201	0	90.01
90.02	09002	0	0	0	1,489	0	90.02
92.00	09200	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
96.00	09600	0	0	0	0	0	96.00
100.00	10000	0	0	0	0	0	100.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
114.00	11400						114.00
118.00		1,707	0	2,125	138,928	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
191.00	19100	0	0	0	54	0	191.00
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		1,707	0	2,125	138,982	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 143027

Period:
From 07/01/2012
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Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	OTHER GENERAL SERVICE	INTERNS & RESIDENTS		
			(SPECIFY)	SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS	
	16.00	17.00	18.00	21.00	22.00	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01 00510	A&G NON INTERN & NON RESIDENT					5.01
5.02 00530	A&G PURCHASING RECEIVING AND STORES					5.02
5.03 00540	A&G ADMITTING					5.03
5.04 00550	A&G PFS - CASHIER /ACCTS RECEIVABLE					5.04
5.05 00560	A&G OTHER A&G IR RELATED					5.05
6.00 00600	MAINTENANCE & REPAIRS					6.00
7.00 00700	OPERATION OF PLANT					7.00
8.00 00800	LAUNDRY & LINEN SERVICE					8.00
9.00 00900	HOUSEKEEPING					9.00
10.00 01000	DIETARY					10.00
11.00 01100	CAFETERIA					11.00
12.00 01200	MAINTENANCE OF PERSONNEL					12.00
13.00 01300	NURSING ADMINISTRATION					13.00
14.00 01400	CENTRAL SERVICES & SUPPLY					14.00
15.00 01500	PHARMACY					15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	18,791				16.00
17.00 01700	SOCIAL SERVICE	0	2,537			17.00
18.00 01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	15,319		18.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	6,744	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0		999 22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	5,682	2,537	15,319		30.00
44.00 04400	SKILLED NURSING FACILITY	2,173	0	0		44.00
46.00 04600	OTHER LONG TERM CARE	0	0	0		46.00
ANCILLARY SERVICE COST CENTERS						
54.00 05400	RADIOLOGY-DIAGNOSTIC	266	0	0		54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	0	0	0		55.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0		58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0		59.00
60.00 06000	LABORATORY	524	0	0		60.00
61.00 06100	PBP CLINICAL LAB SERVICES-PRGM ONLY					61.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0		64.00
65.00 06500	RESPIRATORY THERAPY	371	0	0		65.00
66.00 06600	PHYSICAL THERAPY	1,914	0	0		66.00
67.00 06700	OCCUPATIONAL THERAPY	1,780	0	0		67.00
68.00 06800	SPEECH PATHOLOGY	1,514	0	0		68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0		69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	430	0	0		71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	960	0	0		73.00
74.00 07400	RENAL DIALYSIS	42	0	0		74.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0		90.00
90.01 09001	WHEATON OUTPATIENT	1,944	0	0		90.01
90.02 09002	OTHER DAY HOSPITAL	1,191	0	0		90.02
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)					92.00
OTHER REIMBURSABLE COST CENTERS						
96.00 09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0		96.00
100.00 10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0		100.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
114.00 11400	UTILIZATION REVIEW-SNF					114.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	18,791	2,537	15,319	0	0 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190.00
191.00 19100	RESEARCH	0	0	0		191.00
200.00	Cross Foot Adjustments				6,744	999 200.00
201.00	Negative Cost Centers	0	0	0	0	0 201.00
202.00	TOTAL (sum lines 118-201)	18,791	2,537	15,319	6,744	999 202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 143027

Period:
From 07/01/2012
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Cost Center Description			Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT				4.00
5.01	00510	A&G NON INTERN & NON RESIDENT				5.01
5.02	00530	A&G PURCHASING RECEIVING AND STORES				5.02
5.03	00540	A&G ADMITTING				5.03
5.04	00550	A&G PFS - CASHIER /ACCTS RECEIVABLE				5.04
5.05	00560	A&G OTHER A&G IR RELATED				5.05
6.00	00600	MAINTENANCE & REPAIRS				6.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
12.00	01200	MAINTENANCE OF PERSONNEL				12.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
15.00	01500	PHARMACY				15.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)				18.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD				22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	2,314,088	0	2,314,088	30.00
44.00	04400	SKILLED NURSING FACILITY	373,512	0	373,512	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	26,971	0	26,971	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	55.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000	LABORATORY	8,190	0	8,190	60.00
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY				61.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	7,403	0	7,403	65.00
66.00	06600	PHYSICAL THERAPY	191,399	0	191,399	66.00
67.00	06700	OCCUPATIONAL THERAPY	162,567	0	162,567	67.00
68.00	06800	SPEECH PATHOLOGY	66,348	0	66,348	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	49,608	0	49,608	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	83,412	0	83,412	73.00
74.00	07400	RENAL DIALYSIS	881	0	881	74.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	90.00
90.01	09001	WHEATON OUTPATIENT	50,134	0	50,134	90.01
90.02	09002	OTHER DAY HOSPITAL	99,602	0	99,602	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0		92.00
OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	96.00
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	100.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
114.00	11400	UTILIZATION REVIEW-SNF				114.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	3,434,115	0	3,434,115	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	10,512	0	10,512	190.00
191.00	19100	RESEARCH	122,851	0	122,851	191.00
200.00		Cross Foot Adjustments	7,743	0	7,743	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	3,575,221	0	3,575,221	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 143027

Period:
From 07/01/2012
To 06/30/2013

Worksheet B-1

Date/Time Prepared:
11/20/2013 11:00 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	A&G NON INTERN & NON RESIDENT (INPATIENT CHARGES)	A&G PURCHASING RECEIVING AND STORES (ALLOCATION 1)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	163,260				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		656,063			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	0	0	37,360,660		4.00
5.01 00510	A&G NON INTERN & NON RESIDENT	2,448	44,125	1,458,824	72,798,971	5.01
5.02 00530	A&G PURCHASING RECEIVING AND STORES	0	930	297,395	0	731,432 5.02
5.03 00540	A&G ADMITTING	1,995	1,317	1,088,030	0	11,299 5.03
5.04 00550	A&G PFS - CASHIER /ACCTS RECEIVABLE	0	2,259	636,111	0	1,862 5.04
5.05 00560	A&G OTHER A&G IR RELATED	2,785	34,079	1,542,913	0	25,031 5.05
6.00 00600	MAINTENANCE & REPAIRS	0	0	0	0	0 6.00
7.00 00700	OPERATION OF PLANT	13,735	198,914	301,688	0	67,306 7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0 8.00
9.00 00900	HOUSEKEEPING	1,400	7,232	701,239	0	86,886 9.00
10.00 01000	DIETARY	5,812	19,326	1,095,216	0	11,098 10.00
11.00 01100	CAFETERIA	0	0	0	0	0 11.00
12.00 01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0 12.00
13.00 01300	NURSING ADMINISTRATION	0	358	517,082	0	715 13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	6,291	13,616	161,845	0	36,243 14.00
15.00 01500	PHARMACY	0	0	0	0	0 15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	3,963	1,003,807	0	7,416 16.00
17.00 01700	SOCIAL SERVICE	0	0	832,345	0	0 17.00
18.00 01850	OTHER GENERAL SERVICE (SPECIFY)	723	762	74,145	0	0 18.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	328	1,027,563	0	7,910 21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0 22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	92,377	127,562	9,057,621	26,430,872	129,778 30.00
44.00 04400	SKILLED NURSING FACILITY	15,600	1,301	1,649,686	10,155,910	6,338 44.00
46.00 04600	OTHER LONG TERM CARE	0	0	0	0	0 46.00
ANCILLARY SERVICE COST CENTERS						
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	20,998	320,937	1,211,433	11,733 54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0 55.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0 58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0 59.00
60.00 06000	LABORATORY	0	0	387,457	2,448,343	518 60.00
61.00 06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0 61.00
64.00 06400	INTRAVENOUS THERAPY	0	0	0	0	0 64.00
65.00 06500	RESPIRATORY THERAPY	0	2,174	210,402	1,729,701	13,770 65.00
66.00 06600	PHYSICAL THERAPY	7,759	8,170	2,067,255	8,800,034	11,251 66.00
67.00 06700	OCCUPATIONAL THERAPY	6,797	1,084	1,639,702	8,309,497	4,543 67.00
68.00 06800	SPEECH PATHOLOGY	2,064	4,285	886,414	7,027,313	7,100 68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	0	0	0 69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	2,007,824	117,409 71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0 72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	2,943	8,302	977,512	4,483,890	2,006 73.00
74.00 07400	RENAL DIALYSIS	0	0	0	194,154	328 74.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	0	0	0 90.00
90.01 09001	WHEATON OUTPATIENT	0	36,435	1,844,601	0	14,529 90.01
90.02 09002	OTHER DAY HOSPITAL	0	19,464	1,585,944	0	29,483 90.02
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0 92.00
OTHER REIMBURSABLE COST CENTERS						
96.00 09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0 96.00
100.00 10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0 100.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					
114.00 11400	UTILIZATION REVIEW-SNF					
118.00	SUBTOTALS (SUM OF LINES 1-117)	162,729	556,984	31,365,734	72,798,971	604,552 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	531	0	0	0	0 190.00
191.00 19100	RESEARCH	0	99,079	5,994,926	0	126,880 191.00
200.00	Cross Foot Adjustments					
201.00	Negative Cost Centers					
202.00	Cost to be allocated (per Wkst. B, Part I)	2,649,082	656,064	5,704,947	4,902,536	411,831 202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	16.226155	1.000002	0.152699	0.067343	0.563048 203.00
204.00	Cost to be allocated (per Wkst. B, Part II)			7,626	112,128	3,368 204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.000204	0.001540	0.004605 205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 143027

Period:
From 07/01/2012
To 06/30/2013

Worksheet B-1

Date/Time Prepared:
11/20/2013 11:00 am

Cost Center Description			A&G ADMITTING (GROSS CHARGES)	A&G PFS - CASHIER /ACCTS RECEIVABLE (GROSS CHARGES)	Reconciliation	A&G OTHER A&G IR RELATED (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	
			5.03	5.04	5A.05	5.05	6.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00510	A&G NON INTERN & NON RESIDENT						5.01
5.02	00530	A&G PURCHASING RECEIVING AND STORES						5.02
5.03	00540	A&G ADMITTING	87,685,807					5.03
5.04	00550	A&G PFS - CASHIER /ACCTS RECEIVABLE	0	87,685,807				5.04
5.05	00560	A&G OTHER A&G IR RELATED	0	0	-8,790,667	59,065,766		5.05
6.00	00600	MAINTENANCE & REPAIRS	0	0	0	0	156,032	6.00
7.00	00700	OPERATION OF PLANT	0	0	0	1,528,183	13,735	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	0	0	8.00
9.00	00900	HOUSEKEEPING	0	0	0	1,297,951	1,400	9.00
10.00	01000	DIETARY	0	0	0	1,195,077	5,812	10.00
11.00	01100	CAFETERIA	0	0	0	692,118	0	11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300	NURSING ADMINISTRATION	0	0	0	672,386	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	0	428,324	6,291	14.00
15.00	01500	PHARMACY	0	0	0	0	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	0	1,455,583	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	959,443	0	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	113,107	723	18.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	1,078,086	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	404,963	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	26,430,872	26,430,872	0	18,949,358	92,377	30.00
44.00	04400	SKILLED NURSING FACILITY	10,155,910	10,155,910	0	3,477,450	15,600	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,244,983	1,244,983	0	597,648	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	2,448,343	2,448,343	0	1,059,692	0	60.00
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	1,735,584	1,735,584	0	504,953	0	65.00
66.00	06600	PHYSICAL THERAPY	8,941,622	8,941,622	0	3,619,084	7,759	66.00
67.00	06700	OCCUPATIONAL THERAPY	8,317,361	8,317,361	0	2,998,770	6,797	67.00
68.00	06800	SPEECH PATHOLOGY	7,075,272	7,075,272	0	1,842,648	2,064	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,007,824	2,007,824	0	617,627	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,483,890	4,483,890	0	2,329,979	2,943	73.00
74.00	07400	RENAL DIALYSIS	194,154	194,154	0	112,484	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WHEATON OUTPATIENT	9,082,878	9,082,878	0	2,762,461	0	90.01
90.02	09002	OTHER DAY HOSPITAL	5,567,114	5,567,114	0	2,274,800	0	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	87,685,807	87,685,807	-8,790,667	50,972,175	155,501	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	14,853	531	190.00
191.00	19100	RESEARCH	0	0	0	8,078,738	0	191.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	1,688,066	871,403		8,790,667	0	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.019251	0.009938		0.148828	0.000000	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	33,962	7,572		145,686	0	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000387	0.000086		0.002467	0.000000	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 143027

Period:
From 07/01/2012
To 06/30/2013

Worksheet B-1

Date/Time Prepared:
11/20/2013 11:00 am

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (TOTAL PATIENT DAYS)	CAFETERIA (MEALS SERVED)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.01	00510						5.01
5.02	00530						5.02
5.03	00540						5.03
5.04	00550						5.04
5.05	00560						5.05
6.00	00600						6.00
7.00	00700						7.00
8.00	00800	142,297	0				8.00
9.00	00900	1,400	0	140,897			9.00
10.00	01000	5,812	0	5,812	39,641		10.00
11.00	01100	0	0	0	0	1,000	11.00
12.00	01200	0	0	0	0	0	12.00
13.00	01300	0	0	0	0	0	13.00
14.00	01400	6,291	0	6,291	0	0	14.00
15.00	01500	0	0	0	0	0	15.00
16.00	01600	0	0	0	0	0	16.00
17.00	01700	0	0	0	0	0	17.00
18.00	01850	723	0	723	0	0	18.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	92,377	0	92,377	32,239	1,000	30.00
44.00	04400	15,600	0	15,600	7,402	0	44.00
46.00	04600	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	0	0	0	0	0	54.00
55.00	05500	0	0	0	0	0	55.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	0	0	0	0	0	60.00
61.00	06100	0	0	0	0	0	61.00
64.00	06400	0	0	0	0	0	64.00
65.00	06500	0	0	0	0	0	65.00
66.00	06600	7,759	0	7,759	0	0	66.00
67.00	06700	6,797	0	6,797	0	0	67.00
68.00	06800	2,064	0	2,064	0	0	68.00
69.00	06900	0	0	0	0	0	69.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	2,943	0	2,943	0	0	73.00
74.00	07400	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	0	0	0	0	0	90.00
90.01	09001	0	0	0	0	0	90.01
90.02	09002	0	0	0	0	0	90.02
92.00	09200	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
96.00	09600	0	0	0	0	0	96.00
100.00	10000	0	0	0	0	0	100.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
114.00	11400						114.00
118.00		141,766	0	140,366	39,641	1,000	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	531	0	531	0	0	190.00
191.00	19100	0	0	0	0	0	191.00
200.00							200.00
201.00							201.00
202.00		1,755,619	0	1,508,395	1,506,866	795,125	202.00
203.00		12.337709	0.000000	10.705657	38.012815	795.125000	203.00
204.00		450,793	0	47,042	159,934	1,707	204.00
205.00		3.167973	0.000000	0.333875	4.034560	1.707000	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 143027

Period:
From 07/01/2012
To 06/30/2013

Worksheet B-1

Date/Time Prepared:
11/20/2013 11:00 am

Cost Center Description			MAINTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVICES & SUPPLY (ALLOCATION 2)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (GROSS CHARGES)	
			12.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00510	A&G NON INTERN & NON RESIDENT						5.01
5.02	00530	A&G PURCHASING RECEIVING AND STORES						5.02
5.03	00540	A&G ADMITTING						5.03
5.04	00550	A&G PFS - CASHIER /ACCTS RECEIVABLE						5.04
5.05	00560	A&G OTHER A&G IR RELATED						5.05
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
12.00	01200	MAINTENANCE OF PERSONNEL	0					12.00
13.00	01300	NURSING ADMINISTRATION	0	1,000				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	0	655,350			14.00
15.00	01500	PHARMACY	0	0	0	0		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	0	4,812	0	87,685,807	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	0	17.00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	0	18.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	501	0	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	1,000	408,370	0	26,430,872	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	14,288	0	10,155,910	44.00
46.00	04600	OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	118	0	1,244,983	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	0	55.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	196	0	2,448,343	60.00
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	99	0	1,735,584	65.00
66.00	06600	PHYSICAL THERAPY	0	0	5,010	0	8,941,622	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	3,279	0	8,317,361	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	1,336	0	7,075,272	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	203,095	0	2,007,824	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	5,226	0	4,483,890	73.00
74.00	07400	RENAL DIALYSIS	0	0	799	0	194,154	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	WHEATON OUTPATIENT	0	0	948	0	9,082,878	90.01
90.02	09002	OTHER DAY HOSPITAL	0	0	7,019	0	5,567,114	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
114.00	11400	UTILIZATION REVIEW-SNF						114.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	1,000	655,096	0	87,685,807	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
191.00	19100	RESEARCH	0	0	254	0	0	191.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	0	772,456	637,037	0	1,676,893	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	0.000000	772.456000	0.972056	0.000000	0.019124	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)	0	2,125	138,982	0	18,791	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)	0.000000	2.125000	0.212073	0.000000	0.000214	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 143027

Period:
From 07/01/2012
To 06/30/2013

Worksheet B-1

Date/Time Prepared:
11/20/2013 11:00 am

Cost Center Description	SOCIAL SERVICE (TIME SPENT)	OTHER GENERAL SERVICE	INTERNS & RESIDENTS		
		(SPECIFY) (TIME SPENT)	SERVICES-SALARY & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)	
		17.00	18.00	21.00	
GENERAL SERVICE COST CENTERS					
1.00 00100 CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
5.01 00510 A&G NON INTERN & NON RESIDENT					5.01
5.02 00530 A&G PURCHASING RECEIVING AND STORES					5.02
5.03 00540 A&G ADMITTING					5.03
5.04 00550 A&G PFS - CASHIER /ACCTS RECEIVABLE					5.04
5.05 00560 A&G OTHER A&G IR RELATED					5.05
6.00 00600 MAINTENANCE & REPAIRS					6.00
7.00 00700 OPERATION OF PLANT					7.00
8.00 00800 LAUNDRY & LINEN SERVICE					8.00
9.00 00900 HOUSEKEEPING					9.00
10.00 01000 DIETARY					10.00
11.00 01100 CAFETERIA					11.00
12.00 01200 MAINTENANCE OF PERSONNEL					12.00
13.00 01300 NURSING ADMINISTRATION					13.00
14.00 01400 CENTRAL SERVICES & SUPPLY					14.00
15.00 01500 PHARMACY					15.00
16.00 01600 MEDICAL RECORDS & LIBRARY					16.00
17.00 01700 SOCIAL SERVICE	1,000				17.00
18.00 01850 OTHER GENERAL SERVICE (SPECIFY)	0	1,000			18.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	1,000		21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0		1,000	22.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 03000 ADULTS & PEDIATRICS	1,000	1,000	1,000	1,000	30.00
44.00 04400 SKILLED NURSING FACILITY	0	0	0	0	44.00
46.00 04600 OTHER LONG TERM CARE	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS					
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00 06000 LABORATORY	0	0	0	0	60.00
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	61.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00 09000 CLINIC	0	0	0	0	90.00
90.01 09001 WHEATON OUTPATIENT	0	0	0	0	90.01
90.02 09002 OTHER DAY HOSPITAL	0	0	0	0	90.02
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	96.00
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	100.00
SPECIAL PURPOSE COST CENTERS					
113.00 11300 INTEREST EXPENSE					113.00
114.00 11400 UTILIZATION REVIEW-SNF					114.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	1,000	1,000	1,000	1,000	118.00
NONREIMBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
191.00 19100 RESEARCH	0	0	0	0	191.00
200.00 Cross Foot Adjustments					200.00
201.00 Negative Cost Centers					201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	1,102,235	146,600	1,239,022	465,233	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	1,102.235000	146.600000	1,239.022000	465.233000	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	2,537	15,319	6,744	999	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)	2.537000	15.319000	6.744000	0.999000	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 143027

Period:
From 07/01/2012
To 06/30/2013

Worksheet C
Part I
Date/Time Prepared:
11/20/2013 11:00 am

		Title XVIII		Hospital		PPS
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS		28,842,578		29,186,503	30.00
44.00	04400 SKILLED NURSING FACILITY		4,843,950		4,843,950	44.00
46.00	04600 OTHER LONG TERM CARE		0		0	46.00
ANCILLARY SERVICE COST CENTERS						
54.00	05400 RADIOLOGY-DIAGNOSTIC		710,519		710,519	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC		0		0	55.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		0		0	58.00
59.00	05900 CARDIAC CATHETERIZATION		0		0	59.00
60.00	06000 LABORATORY		1,264,417		1,264,417	60.00
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0		0	61.00
64.00	06400 INTRAVENOUS THERAPY		0		0	64.00
65.00	06500 RESPIRATORY THERAPY		613,391		613,391	65.00
66.00	06600 PHYSICAL THERAPY		4,512,368		4,512,368	66.00
67.00	06700 OCCUPATIONAL THERAPY		3,763,944		3,763,944	67.00
68.00	06800 SPEECH PATHOLOGY		2,301,054		2,301,054	68.00
69.00	06900 ELECTROCARDIOLOGY		0		0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		945,365		945,365	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		0		0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		2,835,392		2,835,392	73.00
74.00	07400 RENAL DIALYSIS		133,715		133,715	74.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC		0		0	90.00
90.01	09001 WHEATON OUTPATIENT		3,348,216		3,348,216	90.01
90.02	09002 OTHER DAY HOSPITAL		2,726,642		2,726,642	90.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0		0	92.00
OTHER REIMBURSABLE COST CENTERS						
96.00	09600 DURABLE MEDICAL EQUIP-RENTED		0		0	96.00
100.00	10000 I&R SERVICES-NOT APPRVD PRGM		0		0	100.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					113.00
114.00	11400 UTILIZATION REVIEW-SNF					114.00
200.00	Subtotal (see instructions)		56,841,551	0	57,185,476	200.00
201.00	Less Observation Beds		0	0	0	201.00
202.00	Total (see instructions)		56,841,551	0	57,185,476	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 143027

Period:
From 07/01/2012
To 06/30/2013

Worksheet C
Part I
Date/Time Prepared:
11/20/2013 11:00 am

		Title XVIII			Hospital	PPS	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	26,430,872		26,430,872		30.00
44.00	04400	SKILLED NURSING FACILITY	10,155,910		10,155,910		44.00
46.00	04600	OTHER LONG TERM CARE	0		0		46.00
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,211,433	33,550	1,244,983	0.570706	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0.000000	55.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	2,448,343	0	2,448,343	0.516438	60.00
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0.000000	61.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	1,729,701	5,883	1,735,584	0.353421	65.00
66.00	06600	PHYSICAL THERAPY	8,800,034	141,588	8,941,622	0.504648	66.00
67.00	06700	OCCUPATIONAL THERAPY	8,309,497	7,864	8,317,361	0.452541	67.00
68.00	06800	SPEECH PATHOLOGY	7,027,313	47,959	7,075,272	0.325225	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	2,007,824	0	2,007,824	0.470841	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,483,890	0	4,483,890	0.632351	73.00
74.00	07400	RENAL DIALYSIS	194,154	0	194,154	0.688706	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0.000000	90.00
90.01	09001	WHEATON OUTPATIENT	0	9,082,878	9,082,878	0.368629	90.01
90.02	09002	OTHER DAY HOSPITAL	0	5,567,114	5,567,114	0.489777	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0.000000	96.00
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0	0	0		100.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
114.00	11400	UTILIZATION REVIEW-SNF					114.00
200.00		Subtotal (see instructions)	72,798,971	14,886,836	87,685,807		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	72,798,971	14,886,836	87,685,807		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 143027	Period: From 07/01/2012 To 06/30/2013	Worksheet C Part I Date/Time Prepared: 11/20/2013 11:00 am
		Title XVIII	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
44.00	04400 SKILLED NURSING FACILITY			44.00
46.00	04600 OTHER LONG TERM CARE			46.00
ANCILLARY SERVICE COST CENTERS				
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.570706		54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000		55.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000 LABORATORY	0.516438		60.00
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000		61.00
64.00	06400 INTRAVENOUS THERAPY	0.000000		64.00
65.00	06500 RESPIRATORY THERAPY	0.353421		65.00
66.00	06600 PHYSICAL THERAPY	0.504648		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.452541		67.00
68.00	06800 SPEECH PATHOLOGY	0.325225		68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.470841		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.632351		73.00
74.00	07400 RENAL DIALYSIS	0.688706		74.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0.000000		90.00
90.01	09001 WHEATON OUTPATIENT	0.368629		90.01
90.02	09002 OTHER DAY HOSPITAL	0.489777		90.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS				
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.000000		96.00
100.00	10000 I&R SERVICES-NOT APPRVD PRGM			100.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300 INTEREST EXPENSE			113.00
114.00	11400 UTILIZATION REVIEW-SNF			114.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 143027		Period: From 07/01/2012 To 06/30/2013		Worksheet D Part I Date/Time Prepared: 11/20/2013 11:00 am	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
Title XVIII Hospital PPS							
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	2,314,088	0	2,314,088	32,239	71.78	30.00
44.00	SKILLED NURSING FACILITY	373,512		373,512	7,402	50.46	44.00
200.00	Total (Lines 30-199)	2,687,600		2,687,600	39,641		200.00
Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)				
		6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	20,401	1,464,384				
44.00	SKILLED NURSING FACILITY	5,058	255,227				
200.00	Total (Lines 30-199)	25,459	1,719,611				

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 143027

Period:
From 07/01/2012
To 06/30/2013

Worksheet D
Part II
Date/Time Prepared:
11/20/2013 11:00 am

Cost Center Description		Title XVIII			Hospital	PPS		
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	26,971	1,244,983	0.021664	932,232	20,196	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0.000000	0	0	55.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	8,190	2,448,343	0.003345	1,620,871	5,422	60.00
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0.000000	0	0	61.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	7,403	1,735,584	0.004265	1,062,130	4,530	65.00
66.00	06600	PHYSICAL THERAPY	191,399	8,941,622	0.021405	5,491,696	117,550	66.00
67.00	06700	OCCUPATIONAL THERAPY	162,567	8,317,361	0.019546	5,210,561	101,846	67.00
68.00	06800	SPEECH PATHOLOGY	66,348	7,075,272	0.009377	4,078,705	38,246	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	49,608	2,007,824	0.024707	1,225,468	30,278	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	83,412	4,483,890	0.018603	2,596,059	48,294	73.00
74.00	07400	RENAL DIALYSIS	881	194,154	0.004538	135,124	613	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0.000000	0	0	90.00
90.01	09001	WHEATON OUTPATIENT	50,134	9,082,878	0.005520	0	0	90.01
90.02	09002	OTHER DAY HOSPITAL	99,602	5,567,114	0.017891	0	0	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0.000000	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0	0	96.00
200.00		Total (lines 50-199)	746,515	51,099,025		22,352,846	366,975	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 143027		Period: From 07/01/2012 To 06/30/2013		Worksheet D Part III Date/Time Prepared: 11/20/2013 11:00 am	
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00
Cost Center Description			Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)		
			6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	32,239	0.00	20,401	0		30.00
44.00	04400	SKILLED NURSING FACILITY	7,402	0.00	5,058	0		44.00
200.00		Total (lines 30-199)	39,641		25,459	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 143027

Period:
From 07/01/2012
To 06/30/2013

Worksheet D
Part IV
Date/Time Prepared:
11/20/2013 11:00 am

Cost Center Description		Title XVIII				Hospital	
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col. 4)	PPS
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY					61.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09001	WHEATON OUTPATIENT	0	0	0	0	90.01
90.02	09002	OTHER DAY HOSPITAL	0	0	0	0	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	96.00
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 143027

Period:
From 07/01/2012
To 06/30/2013

Worksheet D
Part IV
Date/Time Prepared:
11/20/2013 11:00 am

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Hospital		Inpatient Program Charges	
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	PPS		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,244,983	0.000000	0.000000	932,232	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0.000000	0.000000	0	55.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	2,448,343	0.000000	0.000000	1,620,871	60.00
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0.000000	0.000000	0	61.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	1,735,584	0.000000	0.000000	1,062,130	65.00
66.00	06600	PHYSICAL THERAPY	0	8,941,622	0.000000	0.000000	5,491,696	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	8,317,361	0.000000	0.000000	5,210,561	67.00
68.00	06800	SPEECH PATHOLOGY	0	7,075,272	0.000000	0.000000	4,078,705	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,007,824	0.000000	0.000000	1,225,468	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	4,483,890	0.000000	0.000000	2,596,059	73.00
74.00	07400	RENAL DIALYSIS	0	194,154	0.000000	0.000000	135,124	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	0	0.000000	0.000000	0	90.00
90.01	09001	WHEATON OUTPATIENT	0	9,082,878	0.000000	0.000000	0	90.01
90.02	09002	OTHER DAY HOSPITAL	0	5,567,114	0.000000	0.000000	0	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0.000000	0.000000	0	92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0.000000	0	96.00
200.00		Total (lines 50-199)	0	51,099,025			22,352,846	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 143027

Period:
From 07/01/2012
To 06/30/2013

Worksheet D
Part IV
Date/Time Prepared:
11/20/2013 11:00 am

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)		
		11.00	12.00	13.00		
Title XVIII Hospital PPS						
ANCILLARY SERVICE COST CENTERS						
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	33,550	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	55.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	60.00
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	61.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	5,883	0	65.00
66.00	06600	PHYSICAL THERAPY	0	3,043	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	7,864	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC	0	0	0	90.00
90.01	09001	WHEATON OUTPATIENT	0	0	0	90.01
90.02	09002	OTHER DAY HOSPITAL	0	0	0	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	96.00
200.00		Total (lines 50-199)	0	50,340	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 143027	Period: From 07/01/2012 To 06/30/2013	Worksheet D Part V Date/Time Prepared: 11/20/2013 11:00 am
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		Title XVIII		Hospital		PPS		
Cost Center Description		Cost to Charge Ratio From Worksheet C, Part I, col. 9	Charges		Costs			
			PPS Reimbursed Services (see inst.)	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)	PPS Services (see inst.)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.570706	33,550	0	0	19,147	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0.000000	0	0	0	0	55.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.516438	0	0	0	0	60.00
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0	0	0	0	61.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.353421	5,883	0	0	2,079	65.00
66.00	06600	PHYSICAL THERAPY	0.504648	3,043	0	0	1,536	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.452541	7,864	0	0	3,559	67.00
68.00	06800	SPEECH PATHOLOGY	0.325225	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0.470841	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.632351	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0.688706	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.000000	0	0	0	0	90.00
90.01	09001	WHEATON OUTPATIENT	0.368629	0	0	0	0	90.01
90.02	09002	OTHER DAY HOSPITAL	0.489777	0	0	0	0	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	0	0	96.00
200.00		Subtotal (see instructions)		50,340	0	0	26,321	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		50,340	0	0	26,321	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 143027	Period: From 07/01/2012 To 06/30/2013	Worksheet D Part V Date/Time Prepared: 11/20/2013 11:00 am
	Title XVIII	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	54.00
55.00 05500	RADIOLOGY-THERAPEUTIC	0	0	55.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00 06000	LABORATORY	0	0	60.00
61.00 06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	61.00
64.00 06400	INTRAVENOUS THERAPY	0	0	64.00
65.00 06500	RESPIRATORY THERAPY	0	0	65.00
66.00 06600	PHYSICAL THERAPY	0	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00 07400	RENAL DIALYSIS	0	0	74.00
OUTPATIENT SERVICE COST CENTERS				
90.00 09000	CLINIC	0	0	90.00
90.01 09001	WHEATON OUTPATIENT	0	0	90.01
90.02 09002	OTHER DAY HOSPITAL	0	0	90.02
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS				
96.00 09600	DURABLE MEDICAL EQUIP-RENTED	0	0	96.00
200.00	Subtotal (see instructions)	0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0	0	201.00
202.00	Net Charges (line 200 +/- line 201)	0	0	202.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 143027 Component CCN: 146129	Period: From 07/01/2012 To 06/30/2013	Worksheet D Part IV Date/Time Prepared: 11/20/2013 11:00 am
		Title XVIII	Skilled Nursing Facility PPS

Cost Center Description		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
55.00	05500	RADIOLOGY-THERAPEUTIC	0	0	0	0	55.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
61.00	06100	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	61.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09001	WHEATON OUTPATIENT	0	0	0	0	90.01
90.02	09002	OTHER DAY HOSPITAL	0	0	0	0	90.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
96.00	09600	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	96.00
200.00		Total (Lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 143027 Component CCN: 146129	Period: From 07/01/2012 To 06/30/2013	Worksheet D Part IV Date/Time Prepared: 11/20/2013 11:00 am
		Title XVIII	Skilled Nursing Facility PPS

Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
	6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS						
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	1,244,983	0.000000	0.000000	53,669	54.00
55.00 05500 RADIOLOGY-THERAPEUTIC	0	0	0.000000	0.000000	0	55.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00 06000 LABORATORY	0	2,448,343	0.000000	0.000000	196,607	60.00
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0.000000	0.000000	0	61.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0.000000	0.000000	0	64.00
65.00 06500 RESPIRATORY THERAPY	0	1,735,584	0.000000	0.000000	62,908	65.00
66.00 06600 PHYSICAL THERAPY	0	8,941,622	0.000000	0.000000	1,420,452	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	8,317,361	0.000000	0.000000	1,301,648	67.00
68.00 06800 SPEECH PATHOLOGY	0	7,075,272	0.000000	0.000000	181,937	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0.000000	0.000000	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2,007,824	0.000000	0.000000	47,289	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	4,483,890	0.000000	0.000000	515,283	73.00
74.00 07400 RENAL DIALYSIS	0	194,154	0.000000	0.000000	0	74.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000 CLINIC	0	0	0.000000	0.000000	0	90.00
90.01 09001 WHEATON OUTPATIENT	0	9,082,878	0.000000	0.000000	0	90.01
90.02 09002 OTHER DAY HOSPITAL	0	5,567,114	0.000000	0.000000	0	90.02
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0.000000	0.000000	0	92.00
OTHER REIMBURSABLE COST CENTERS						
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000	0.000000	0	96.00
200.00 Total (lines 50-199)	0	51,099,025			3,779,793	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 143027 Component CCN: 146129	Period: From 07/01/2012 To 06/30/2013	Worksheet D Part IV Date/Time Prepared: 11/20/2013 11:00 am PPS
Title XVIII		Skilled Nursing Facility	

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	
		11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS					
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0	0	0	55.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	60.00
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	61.00
64.00	06400 INTRAVENOUS THERAPY	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0	0	0	90.00
90.01	09001 WHEATON OUTPATIENT	0	0	0	90.01
90.02	09002 OTHER DAY HOSPITAL	0	0	0	90.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	96.00
200.00	Total (lines 50-199)	0	0	0	200.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 143027	Period: From 07/01/2012 To 06/30/2013	Worksheet D-1
		Title XVIII	Hospital	Date/Time Prepared: 11/20/2013 11:00 am
Cost Center Description				PPS
				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		32,239	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		32,239	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		32,239	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		20,401	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		29,186,503	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		29,186,503	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		29,186,503	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		905.32	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		18,469,433	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		18,469,433	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 143027	Period: From 07/01/2012 To 06/30/2013	Worksheet D-1 Date/Time Prepared: 11/20/2013 11:00 am
Cost Center Description			Title XVIII		PPS
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)				42.00
Intensive Care Type Inpatient Hospital Units					
43.00	INTENSIVE CARE UNIT				43.00
44.00	CORONARY CARE UNIT				44.00
45.00	BURN INTENSIVE CARE UNIT				45.00
46.00	SURGICAL INTENSIVE CARE UNIT				46.00
47.00	OTHER SPECIAL CARE (SPECIFY)				47.00
Cost Center Description					
					1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)				10,512,033
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				28,981,466
PASS THROUGH COST ADJUSTMENTS					
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)				1,464,384
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				366,975
52.00	Total Program excludable cost (sum of lines 50 and 51)				1,831,359
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				27,150,107
TARGET AMOUNT AND LIMIT COMPUTATION					
54.00	Program discharges				0
55.00	Target amount per discharge				0.00
56.00	Target amount (line 54 x line 55)				0
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)				0
58.00	Bonus payment (see instructions)				0
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket				0.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket				0.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)				0
62.00	Relief payment (see instructions)				0
63.00	Allowable Inpatient cost plus incentive payment (see instructions)				0
PROGRAM INPATIENT ROUTINE SWING BED COST					
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)				0
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)				0
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)				0
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)				0
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)				0
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)				0
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY					
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)				70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)				71.00
72.00	Program routine service cost (line 9 x line 71)				72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)				73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)				74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)				75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)				76.00
77.00	Program capital-related costs (line 9 x line 76)				77.00
78.00	Inpatient routine service cost (line 74 minus line 77)				78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)				79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)				80.00
81.00	Inpatient routine service cost per diem limitation				81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)				82.00
83.00	Reasonable inpatient routine service costs (see instructions)				83.00
84.00	Program inpatient ancillary services (see instructions)				84.00
85.00	Utilization review - physician compensation (see instructions)				85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)				86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					
87.00	Total observation bed days (see instructions)				0
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				0.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)				0

COMPUTATION OF INPATIENT OPERATING COST

Provider CCN: 143027

Period:
From 07/01/2012
To 06/30/2013

Worksheet D-1
Date/Time Prepared:
11/20/2013 11:00 am

Cost Center Description		Cost	Title XVIII		Hospital	PPS	
			Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	2,314,088	29,186,503	0.079286	0	0	90.00
91.00	Nursing School cost	0	29,186,503	0.000000	0	0	91.00
92.00	Allied health cost	0	29,186,503	0.000000	0	0	92.00
93.00	All other Medical Education	0	29,186,503	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 143027 Component CCN: 146129	Period: From 07/01/2012 To 06/30/2013	Worksheet D-1 Date/Time Prepared: 11/20/2013 11:00 am
		Title XVIII	Skilled Nursing Facility	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		7,402	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		7,402	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		7,402	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		5,058	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		4,843,950	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		4,843,950	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		4,843,950	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)			38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)			39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)			40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)			41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 143027	Period: From 07/01/2012 To 06/30/2013	Worksheet D-1	
		Component CCN: 146129		Date/Time Prepared: 11/20/2013 11:00 am	
		Title XVIII	Skilled Nursing Facility	PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)
	1.00	2.00	3.00	4.00	5.00
42.00	NURSERY (title V & XIX only)				42.00
	Intensive Care Type Inpatient Hospital Units				
43.00	INTENSIVE CARE UNIT				43.00
44.00	CORONARY CARE UNIT				44.00
45.00	BURN INTENSIVE CARE UNIT				45.00
46.00	SURGICAL INTENSIVE CARE UNIT				46.00
47.00	OTHER SPECIAL CARE (SPECIFY)				47.00
	Cost Center Description				
					1.00
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)				48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				49.00
	PASS THROUGH COST ADJUSTMENTS				
50.00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)				50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)				52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				53.00
	TARGET AMOUNT AND LIMIT COMPUTATION				
54.00	Program discharges				54.00
55.00	Target amount per discharge				55.00
56.00	Target amount (line 54 x line 55)				56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)				57.00
58.00	Bonus payment (see instructions)				58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket				59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket				60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)				61.00
62.00	Relief payment (see instructions)				62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)				63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST				
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)				64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)				65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)				66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)				67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)				68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)				69.00
	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY				
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)				4,843,950 70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)				654.41 71.00
72.00	Program routine service cost (line 9 x line 71)				3,310,006 72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)				0 73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)				3,310,006 74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)				0 75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)				0.00 76.00
77.00	Program capital-related costs (line 9 x line 76)				0 77.00
78.00	Inpatient routine service cost (line 74 minus line 77)				0 78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)				0 79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)				0 80.00
81.00	Inpatient routine service cost per diem limitation				0.00 81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)				0 82.00
83.00	Reasonable inpatient routine service costs (see instructions)				3,310,006 83.00
84.00	Program inpatient ancillary services (see instructions)				1,867,550 84.00
85.00	Utilization review - physician compensation (see instructions)				0 85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)				5,177,556 86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST				
87.00	Total observation bed days (see instructions)				0 87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				0.00 88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)				0 89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 143027 Component CCN: 146129		Period: From 07/01/2012 To 06/30/2013		Worksheet D-1 Date/Time Prepared: 11/20/2013 11:00 am	
		Title XVIII		Skilled Nursing Facility		PPS	
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital -related cost	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 143027	Period: From 07/01/2012 To 06/30/2013	Worksheet D-3 Date/Time Prepared: 11/20/2013 11:00 am	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS		15,625,115		30.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.570706	932,232	532,030	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	0	0	55.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000 LABORATORY	0.516438	1,620,871	837,079	60.00
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0	0	61.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.353421	1,062,130	375,379	65.00
66.00	06600 PHYSICAL THERAPY	0.504648	5,491,696	2,771,373	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.452541	5,210,561	2,357,992	67.00
68.00	06800 SPEECH PATHOLOGY	0.325225	4,078,705	1,326,497	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.470841	1,225,468	577,001	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.632351	2,596,059	1,641,621	73.00
74.00	07400 RENAL DIALYSIS	0.688706	135,124	93,061	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.000000	0	0	90.00
90.01	09001 WHEATON OUTPATIENT	0.368629	0	0	90.01
90.02	09002 OTHER DAY HOSPITAL	0.489777	0	0	90.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	96.00
200.00	Total (sum of lines 50-94 and 96-98)		22,352,846	10,512,033	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net Charges (line 200 minus line 201)		22,352,846		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 143027 Component CCN: 146129	Period: From 07/01/2012 To 06/30/2013	Worksheet D-3 Date/Time Prepared: 11/20/2013 11:00 am	
		Title XVIII	Skilled Nursing Facility	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS			2,827,302	30.00
ANCILLARY SERVICE COST CENTERS					
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.570706	53,669	30,629	54.00
55.00	05500 RADIOLOGY-THERAPEUTIC	0.000000	0	0	55.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000 LABORATORY	0.516438	196,607	101,535	60.00
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0	0	61.00
64.00	06400 INTRAVENOUS THERAPY	0.000000	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0.353421	62,908	22,233	65.00
66.00	06600 PHYSICAL THERAPY	0.504648	1,420,452	716,828	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.452541	1,301,648	589,049	67.00
68.00	06800 SPEECH PATHOLOGY	0.325225	181,937	59,170	68.00
69.00	06900 ELECTROCARDIOLOGY	0.000000	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.470841	47,289	22,266	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.632351	515,283	325,840	73.00
74.00	07400 RENAL DIALYSIS	0.688706	0	0	74.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0.000000	0	0	90.00
90.01	09001 WHEATON OUTPATIENT	0.368629	0	0	90.01
90.02	09002 OTHER DAY HOSPITAL	0.489777	0	0	90.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.000000	0	0	96.00
200.00	Total (sum of lines 50-94 and 96-98)		3,779,793	1,867,550	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net Charges (line 200 minus line 201)		3,779,793		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 143027	Period: From 07/01/2012 To 06/30/2013	Worksheet E Part B Date/Time Prepared: 11/20/2013 11:00 am
		Title XVII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			0 1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)			26,321 2.00
3.00	PPS payments			12,484 3.00
4.00	Outlier payment (see instructions)			0 4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0.943 5.00
6.00	Line 2 times line 5			24,821 6.00
7.00	Sum of line 3 plus line 4 divided by line 6			50.30 7.00
8.00	Transitional corridor payment (see instructions)			0 8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200			0 9.00
10.00	Organ acquisitions			0 10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			0 11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges			0 12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)			0 13.00
14.00	Total reasonable charges (sum of lines 12 and 13)			0 14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis			0 15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)			0 16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000 17.00
18.00	Total customary charges (see instructions)			0 18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)			0 19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)			0 20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)			0 21.00
22.00	Interns and residents (see instructions)			0 22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)			0 23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)			12,484 24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)			0 25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)			3,406 26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)			9,078 27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)			540 28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)			0 29.00
30.00	Subtotal (sum of lines 27 through 29)			9,618 30.00
31.00	Primary payer payments			0 31.00
32.00	Subtotal (line 30 minus line 31)			9,618 32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Worksheet I-5, line 11)			0 33.00
34.00	Allowable bad debts (see instructions)			21,399 34.00
35.00	Adjusted reimbursable bad debts (see instructions)			14,979 35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)			0 36.00
37.00	Subtotal (see instructions)			24,597 37.00
38.00	MSP-LCC reconciliation amount from PS&R			0 38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 39.00
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0 39.99
40.00	Subtotal (see instructions)			24,597 40.00
40.01	Sequestration adjustment (see instructions)			123 40.01
41.00	Interim payments			9,016 41.00
42.00	Tentative settlement (for contractors use only)			0 42.00
43.00	Balance due provider/program (see instructions)			15,458 43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2			0 44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0 90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0 91.00
92.00	The rate used to calculate the Time Value of Money			0.00 92.00
93.00	Time Value of Money (see instructions)			0 93.00
94.00	Total (sum of lines 91 and 93)			0 94.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 143027

Period:
From 07/01/2012
To 06/30/2013

Worksheet E-1
Part I
Date/Time Prepared:
11/20/2013 11:00 am

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		29,567,309		9,016	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00	
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		29,567,309		9,016	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00	
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00	
6.01	SETTLEMENT TO PROVIDER		269,626		15,581	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		29,836,935		24,597	7.00	
				Contractor Number	NPR Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 143027
Component CCN: 146129

Period:
From 07/01/2012
To 06/30/2013

Worksheet E-1
Part I
Date/Time Prepared:
11/20/2013 11:00 am
PPS

Title XVIII
Skilled Nursing Facility

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider					1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		2,320,504		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2,320,504		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		12,943		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		2,333,447		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 143027	Period: From 07/01/2012 To 06/30/2013	Worksheet E-3 Part III Date/Time Prepared: 11/20/2013 11:00 am
		Title XVIII	Hospital	PPS
		1.00		
PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)		25,655,771	1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)		0.0116	2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)		1,187,862	3.00
4.00	Outlier Payments		107,321	4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)		12.75	5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)		0.00	5.01
6.00	New Teaching program adjustment. (see instructions)		0.00	6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program". (see inst.)		14.88	7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program". (see inst.)		0.00	8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)		12.75	9.00
10.00	Average Daily Census (see instructions)		88.326027	10.00
11.00	Indirect Medical Education Adjustment Factor $\{((1 + (\text{line 9}/\text{line 10})) \text{ raised to the power of } .6876 - 1)\}$.		0.097149	11.00
12.00	Indirect Medical Education Adjustment (line 1 multiplied by line 11).		2,492,432	12.00
13.00	Total PPS Payment (sum of lines 1, 3, 4 and 12)		29,443,386	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)		0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)			15.00
16.00	Cost of teaching physicians (from Worksheet D-5, Part II, column 3, line 20) (see instructions)		0	16.00
17.00	Subtotal (see instructions)		29,443,386	17.00
18.00	Primary payer payments		47,328	18.00
19.00	Subtotal (line 17 less line 18).		29,396,058	19.00
20.00	Deductibles		164,760	20.00
21.00	Subtotal (line 19 minus line 20)		29,231,298	21.00
22.00	Coinsurance		137,168	22.00
23.00	Subtotal (line 21 minus line 22)		29,094,130	23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		43,229	24.00
25.00	Adjusted reimbursable bad debts (see instructions)		30,260	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	26.00
27.00	Subtotal (sum of lines 23 and 25)		29,124,390	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 49)		712,182	28.00
29.00	Other pass through costs (see instructions)		0	29.00
30.00	Outlier payments reconciliation		0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) ()		0	31.00
31.01	MSP PASS THROUGH		363	31.01
31.02			0	31.02
31.99	Recovery of Accelerated Depreciation		0	31.99
32.00	Total amount payable to the provider (see instructions)		29,836,935	32.00
32.01	Sequestration adjustment (see instructions)		149,185	32.01
33.00	Interim payments		29,567,309	33.00
34.00	Tentative settlement (for contractor use only)		0	34.00
35.00	Balance due provider/program line 32 minus lines 32.01, 33 and 34		120,441	35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, section 115.2		0	36.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part III, line 4		107,321	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)		0	51.00
52.00	The rate used to calculate the Time Value of Money		0.00	52.00
53.00	Time Value of Money (see instructions)		0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 143027 Component CCN: 146129	Period: From 07/01/2012 To 06/30/2013	Worksheet E-3 Part VI Date/Time Prepared: 11/20/2013 11:00 am
		Title XVIII	Skilled Nursing Facility	PPS
				1.00
PART VI - CALCULATION OF REIMBURSEMENT SETTLEMENT - ALL OTHER HEALTH SERVICES FOR TITLE XVIII PART A PPS SNF SERVICES				
PROSPECTIVE PAYMENT AMOUNT (SEE INSTRUCTIONS)				
1.00	Resource Utilization Group Payment (RUGS)		2,513,432	1.00
2.00	Routine service other pass through costs		0	2.00
3.00	Ancillary service other pass through costs		0	3.00
4.00	Subtotal (sum of lines 1 through 3)		2,513,432	4.00
COMPUTATION OF NET COST OF COVERED SERVICES				
5.00	Medical and other services (Do not use this line as vaccine costs are included in line 1 of W/S E, Part B. This line is now shaded.)			5.00
6.00	Deductible		0	6.00
7.00	Coinsurance		180,898	7.00
8.00	Allowable bad debts (see instructions)		1,731	8.00
9.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)		0	9.00
10.00	Adjusted reimbursable bad debts (see instructions)		1,212	10.00
11.00	Utilization review		0	11.00
12.00	Subtotal (Sum of lines 4, 5 minus 6 & 7 plus 10 and 11)(see Instructions)		2,333,746	12.00
13.00	Inpatient primary payer payments		299	13.00
14.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	14.00
14.99	Recovery of Accelerated Depreciation		0	14.99
15.00	Subtotal (line 12 minus 13 ± lines 14)		2,333,447	15.00
15.01	Sequestration adjustment (see instructions)		11,667	15.01
16.00	Interim payments		2,320,504	16.00
17.00	Tentative settlement (for contractor use only)		0	17.00
18.00	Balance due provider/program line 15 minus 15.01, 16 and 17		1,276	18.00
19.00	Protested amounts (nonallowable cost report items) in accordance with CMS 19 Pub. 15-2, section 115.2		0	19.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 143027	Period: From 07/01/2012 To 06/30/2013	Worksheet E-4 Date/Time Prepared: 11/20/2013 11:00 am	
		Title XVII	Hospital	PPS	
				1.00	
COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			12.60	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with 42 CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus lines 4.01 and 4.02 plus applicable subscripts)			12.60	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			14.88	6.00
7.00	Enter the lesser of line 5 or line 6			12.60	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	0.00	11.88	11.88	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	0.00	10.06	10.06	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00		10.00
11.00	Total weighted FTE count	0.00	10.06		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	0.00	13.33		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	0.00	9.71		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	0.00	11.03		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
17.00	Adjusted rolling average FTE count	0.00	11.03		17.00
18.00	Per resident amount	0.00	102,081.51		18.00
19.00	Approved amount for resident costs	0	1,125,959	1,125,959	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			2.28	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locally adjustment national average per resident amount (see instructions)			0.00	23.00
24.00	Multiply line 22 time line 23			0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			1,125,959	25.00
		Inpatient Part A	Managed care		
		1.00	2.00	3.00	
COMPUTATION OF PROGRAM PATIENT LOAD					
26.00	Inpatient Days	20,401	7		26.00
27.00	Total Inpatient Days (see instructions)	32,239	32,239		27.00
28.00	Ratio of inpatient days to total inpatient days	0.632805	0.000217		28.00
29.00	Program direct GME amount	712,512	244		29.00
30.00	Reduction for direct GME payments for Medicare managed care		34		30.00
31.00	Net Program direct GME amount			712,722	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 143027	Period: From 07/01/2012 To 06/30/2013	Worksheet E-4 Date/Time Prepared: 11/20/2013 11:00 am
		Title XVIII	Hospital	PPS
				1.00
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32.00	Renal dialysis direct medical education costs (from Worksheet B, Part I, sum of columns 20 and 23, lines 74 and 94)		0	32.00
33.00	Renal dialysis and home dialysis total charges (Worksheet C, Part I, column 8, sum of lines 74 and 94)		194,154	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)		0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)		0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)		0	36.00
APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY				
Part A Reasonable Cost				
37.00	Reasonable cost (see instructions)		34,804,904	37.00
38.00	Organ acquisition costs (Worksheet D-4, Part III, column 1, line 69)		0	38.00
39.00	Cost of teaching physicians (Worksheet D-5, Part II, column 3, line 20)		0	39.00
40.00	Primary payer payments (see instructions)		47,627	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)		34,757,277	41.00
Part B Reasonable Cost				
42.00	Reasonable cost (see instructions)		26,321	42.00
43.00	Primary payer payments (see instructions)		0	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)		26,321	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)		34,783,598	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)		0.999243	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)		0.000757	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48.00	Total program GME payment (line 31)		712,722	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (Title XVIII only) (see instructions)		712,182	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)		540	50.00

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

Provider CCN: 143027

Period:
From 07/01/2012
To 06/30/2013

Worksheet G

Date/Time Prepared:
11/20/2013 11:00 am

		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3.00	4.00	
CURRENT ASSETS						
1.00	Cash on hand in banks	17,322,116	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	10,843,017	0	0	0	4.00
5.00	Other receivable	0	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	223,568	0	0	0	7.00
8.00	Prepaid expenses	644,647	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	145,372	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	29,178,720	0	0	0	11.00
FIXED ASSETS						
12.00	Land	1,100,074	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	78,105,148	0	0	0	15.00
16.00	Accumulated depreciation	-21,812,433	0	0	0	16.00
17.00	Leasehold improvements	297,527	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	10,318,650	0	0	0	19.00
20.00	Accumulated depreciation	-7,047,777	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	60,961,189	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	90,139,909	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	4,808,973	0	0	0	37.00
38.00	Salaries, wages, and fees payable	0	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	757,406	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	946,208	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	6,512,587	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	32,458,672	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	384,443	0	0	0	48.00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	32,843,115	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	39,355,702	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	50,784,207				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	50,784,207	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	90,139,909	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 143027

Period:
From 07/01/2012
To 06/30/2013

Worksheet G-1

Date/Time Prepared:
11/20/2013 11:00 am

		General Fund		Special Purpose Fund		Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00	Fund balances at beginning of period		51,163,877			0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		2,588,927				2.00
3.00	Total (sum of line 1 and line 2)		53,752,804			0	3.00
4.00	Additions (credit adjustments) (specify)	60,295		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		60,295			0	10.00
11.00	Subtotal (line 3 plus line 10)		53,813,099			0	11.00
12.00	Deductions (debit adjustments) (specify)	3,028,892		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		3,028,892			0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		50,784,207			0	19.00
		Endowment Fund		Plant Fund			
		6.00	7.00	8.00			
1.00	Fund balances at beginning of period	0		0			1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0		0			3.00
4.00	Additions (credit adjustments) (specify)		0				4.00
5.00			0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9.00
10.00	Total additions (sum of line 4-9)	0		0			10.00
11.00	Subtotal (line 3 plus line 10)	0		0			11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13.00			0				13.00
14.00			0				14.00
15.00			0				15.00
16.00			0				16.00
17.00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		0			18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0			19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 143027

Period:
From 07/01/2012
To 06/30/2013

Worksheet G-2
Parts I & II
Date/Time Prepared:
11/20/2013 11:00 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	62,643,561		62,643,561	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	10,155,910		10,155,910	7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE	0		0	9.00
10.00	Total general inpatient care services (sum of lines 1-9)	72,799,471		72,799,471	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	72,799,471		72,799,471	17.00
18.00	Ancillary services	0	0	0	18.00
19.00	Outpatient services	0	14,886,336	14,886,336	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	72,799,471	14,886,336	87,685,807	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		70,182,339		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00		0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		70,182,339		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 143027

Period:
From 07/01/2012
To 06/30/2013

Worksheet G-3

Date/Time Prepared:
11/20/2013 11:00 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	87,685,807	1.00
2.00	Less contractual allowances and discounts on patients' accounts	25,974,364	2.00
3.00	Net patient revenues (line 1 minus line 2)	61,711,443	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	70,182,339	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-8,470,896	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	571,876	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	OTHER (SPECIFY)	6,666,865	24.00
24.01	GRANT & OTHER	2,481,528	24.01
24.02	CONTRACT MANAGEMENT	1,057,412	24.02
24.03	NET ASSETS RELEASED	382,279	24.03
25.00	Total other income (sum of lines 6-24)	11,159,960	25.00
26.00	Total (line 5 plus line 25)	2,689,064	26.00
27.00	OTHER EXPENSES (CONTRIB & SALEASSET)	100,137	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	100,137	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	2,588,927	29.00