

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION AND SETTLEMENT SUMMARY	Provider CCN: 140213	Period: From 10/01/2014 To 09/30/2015	Worksheet S Parts I-III Date/Time Prepared: 2/19/2016 2:55 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: _____ Time: _____
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: _____ 7. Contractor No. _____ 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN 10. NPR Date: _____ 11. Contractor's Vendor Code: _____ 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by SILVER CROSS HOSPITAL (140213) for the cost reporting period beginning 10/01/2014 and ending 09/30/2015 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

_____ Title

_____ Date

	Title V 1.00	Title XVIII		HIT 4.00	Title XIX 5.00	
		Part A 2.00	Part B 3.00			
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	-360,275	-31,046	1,506,260	0	1.00
2.00 Subprovider - IPF	0	50,365	0		0	2.00
3.00 Subprovider - IRF	0	46,889	0		0	3.00
4.00 SUBPROVIDER I	0	0	0		0	4.00
5.00 Swing bed - SNF	0	0	0		0	5.00
6.00 Swing bed - NF	0				0	6.00
7.00 SKILLED NURSING FACILITY	0	0	0		0	7.00
8.00 NURSING FACILITY	0				0	8.00
9.00 HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00 RURAL HEALTH CLINIC I	0				0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0				0	11.00
12.00 CMHC I	0				0	12.00
200.00 Total	0	-263,021	-31,046	1,506,260	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. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDI-CARE.

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140213		Period: From 10/01/2014 To 09/30/2015		Worksheet S-2 Part I Date/Time Prepared: 2/19/2016 2:55 am					
1.00		2.00		3.00		4.00					
Hospital and Hospital Health Care Complex Address:											
1.00	Street: 1900 SILVER CROSS BLVD.		PO Box:				1.00				
2.00	City: NEW LENOX		State: IL		Zip Code: 60451		County: WILL				
		Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00		
Hospital and Hospital-Based Component Identification:											
3.00	Hospital		SILVER CROSS HOSPITAL	140213	16974	1	07/01/1966	N	P	P	3.00
4.00	Subprovider - IPF		SCH - MENTAL HEALTH CARE UNIT	14S213	16974	4	04/01/1991	N	P	P	4.00
5.00	Subprovider - IRF		SCH - REHAB	14T213	16974	5	10/01/2000	N	P	P	5.00
6.00	Subprovider - (Other)										6.00
7.00	Swing Beds - SNF										7.00
8.00	Swing Beds - NF										8.00
9.00	Hospital-Based SNF										9.00
10.00	Hospital-Based NF										10.00
11.00	Hospital-Based OLTC										11.00
12.00	Hospital-Based HHA		SCH HOME HEALTH	147452	16974		04/01/1994	N	P	N	12.00
13.00	Separately Certified ASC										13.00
14.00	Hospital-Based Hospice										14.00
15.00	Hospital-Based Health Clinic - RHC										15.00
16.00	Hospital-Based Health Clinic - FQHC										16.00
17.00	Hospital-Based (CMHC) I										17.00
17.10	Hospital-Based (CORF) I										17.10
18.00	Renal Dialysis										18.00
18.01											18.01
18.02											18.02
19.00	Other										19.00
						From:	To:				
						1.00	2.00				
20.00	Cost Reporting Period (mm/dd/yyyy)					10/01/2014	09/30/2015		20.00		
21.00	Type of Control (see instructions)					1				21.00	
Inpatient PPS Information											
22.00	Does this facility qualify and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N		22.00		
22.01	Did this hospital receive interim uncompensated care payments for this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions)					N	Y		22.01		
22.02	Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1.					N	N		22.02		
22.03	Did this hospital receive a geographic reclassification from urban to rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.					N	N		22.03		
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					1	N		23.00		
			In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days			
			1.00	2.00	3.00	4.00	5.00	6.00			
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.		5,947	3,158	0	0	1,166	0	24.00		

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		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of- State Medicaid paid days	Out-of- State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days		
		1.00	2.00	3.00	4.00	5.00	6.00		
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	132	46	0	0	41		25.00	
						Urban/Rural	S	Date of Geogr	
						1.00		2.00	
26.00	Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.					1		26.00	
27.00	Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, enter the effective date of the geographic reclassification in column 2.					1		27.00	
35.00	If this is a sole community hospital (SCH), enter the number of periods SCH status in effect in the cost reporting period.					0		35.00	
						Beginning:	Ending:		
						1.00	2.00		
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.							36.00	
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in effect in the cost reporting period.					0		37.00	
38.00	If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38.00	
						Y/N	Y/N		
						1.00	2.00		
39.00	Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)					N	N	39.00	
40.00	Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions)					N	N	40.00	
						V	XVII	XIX	
						1.00	2.00	3.00	
Prospective Payment System (PPS)-Capital									
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)					N	Y	N	45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III.					N	N	N	46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.					N	N	N	47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.					N	N	N	48.00
Teaching Hospitals									
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.					N			56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.								57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5.					N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I.					N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)					Y			60.00
		Y/N	IME	Direct GME	IME	Direct GME			
		1.00	2.00	3.00	4.00	5.00			
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N				0.00		0.00	61.00
61.01	Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)		0.00	0.00					61.01
61.02	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00					61.02

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	Y/N	IME	Direct GME	IME	Direct GME		
	1.00	2.00	3.00	4.00	5.00		
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/surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).	0.00	0.00				61.04
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)	0.00	0.00				61.05
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)	0.00	0.00				61.06
		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count		
		1.00	2.00	3.00	4.00		
61.10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00		61.10
61.20	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.			0.00	0.00		61.20
					1.00		
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)							
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)				0.00		62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)				0.00		62.01
Teaching Hospitals that Claim Residents in Nonprovider Settings							
63.00	Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)				N		63.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))		
			1.00	2.00	3.00		
Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting period that begins on or after July 1, 2009 and before June 30, 2010.							
64.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	64.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	

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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	4.00	5.00		
65.00	Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000		65.00
			Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))		
			1.00	2.00	3.00		
Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010							
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)		0.00	0.00	0.000000		66.00
	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))		
	1.00	2.00	3.00	4.00	5.00		
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)		0.00	0.00	0.000000		67.00
					1.00	2.00	3.00
Inpatient Psychiatric Facility PPS							
70.00	Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? Enter "Y" for yes or "N" for no.				Y		70.00
71.00	If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				N	0	71.00
Inpatient Rehabilitation Facility PPS							
75.00	Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no.				Y		75.00
76.00	If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)				N	0	76.00

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				1.00	
Long Term Care Hospital PPS					
80.00	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N	80.00
81.00	Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter "Y" for yes and "N" for no.			N	81.00
TEFRA Providers					
85.00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no.			N	85.00
86.00	Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				86.00
87.00	Is this hospital a "subclause (II)" LTCH classified under section 1886(d)(1)(B)(iv)(II)? Enter "Y" for yes or "N" for no.			N	87.00
		V	XIX		
		1.00	2.00		
Title V and XIX Services					
90.00	Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y	90.00	
91.00	Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N	92.00
93.00	Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	95.00	
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N	N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.	0.00	0.00	97.00	
Rural Providers					
105.00	Does this hospital qualify as a critical access hospital (CAH)?			N	105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			N	106.00
107.00	If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. 1, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. 11.			N	107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			N	108.00
		Physical 1.00	Occupational 2.00	Speech 3.00	Respiratory 4.00
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N
				1.00	
110.00	Did this hospital participate in the Rural Community Hospital Demonstration project (410A Demo) for the current cost reporting period? Enter "Y" for yes or "N" for no.			N	110.00
		1.00	2.00	3.00	
Miscellaneous Cost Reporting Information					
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If column 1 is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospitals providers) based on the definition in CMS Pub.15-1, chapter 22, §2208.1.	N		0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N			116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	N			117.00
118.00	Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if the policy is claim-made. Enter 2 if the policy is occurrence.	0			118.00
		Premiums 1.00	Losses 2.00	Insurance 3.00	
118.01	List amounts of malpractice premiums and paid losses:	0	0	0	118.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140213	Period: From 10/01/2014 To 09/30/2015	Worksheet S-2 Part I Date/Time Prepared: 2/19/2016 2:55 am	
		1.00	2.00		
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.	N		118.02	
119.00	DO NOT USE THIS LINE			119.00	
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2, "Y" for yes or "N" for no.	N	N	120.00	
121.00	Did this facility incur and report costs for high cost implantable devices charged to patients? Enter "Y" for yes or "N" for no.	Y		121.00	
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	N		125.00	
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			126.00	
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			127.00	
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			128.00	
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			129.00	
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			130.00	
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			131.00	
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			132.00	
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.			133.00	
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.			134.00	
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)	Y		140.00	
		1.00	2.00	3.00	
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.					
141.00	Name:	Contractor's Name:	Contractor's Number:		
142.00	Street:	PO Box:			
143.00	City:	State:	Zip Code:		
			1.00		
144.00	Are provider based physicians' costs included in Worksheet A?		Y	144.00	
		1.00	2.00		
145.00	If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2.	Y		145.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.	N		146.00	
			1.00		
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.		N	147.00	
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.		N	148.00	
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.		N	149.00	
		Part A	Part B	Title V	Title XIX
		1.00	2.00	3.00	4.00
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N
156.00	Subprovider - IPF	N	N	N	N
157.00	Subprovider - IRF	N	N	N	N
158.00	SUBPROVIDER				
159.00	SNF	N	N	N	N
160.00	HOME HEALTH AGENCY	N	N	N	N
161.00	CMHC		N	N	N
161.10	CORF		N	N	N

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140213		Period: From 10/01/2014 To 09/30/2015		Worksheet S-2 Part I Date/Time Prepared: 2/19/2016 2:55 am		
							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	County	State	Zip Code	CBSA	FTE/Campus	
		0	1.00	2.00	3.00	4.00	5.00	
166.00	If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.00	166.00
							1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act								
167.00	Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.						Y	167.00
168.00	If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)							168.00
168.01	If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)							168.01
169.00	If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)						0.50	169.00
						Beginning	Ending	
						1.00	2.00	
170.00	Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)				10/01/2014	09/30/2015	170.00	
							1.00	
171.00	If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. 1, line 2, col. 6? Enter "Y" for yes and "N" for no. (see instructions)						Y	171.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 140213	Period: From 10/01/2014 To 09/30/2015	Worksheet S-2 Part II Date/Time Prepared: 2/19/2016 2:55 am	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00
			Y/N	Type	Date
			1.00	2.00	3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	Y	A		4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	Y			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Interns and Residents in an approved graduate medical education program in the current cost report? If yes, see instructions.	N			9.00
10.00	Was an approved Intern and Resident GME program initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
				Y/N	
				1.00	
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			Y	15.00
		Part A		Part B	
Description		Y/N	Date	Y/N	
0		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)	Y	01/25/2016	Y	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: 140213

Period:
From 10/01/2014
To 09/30/2015

Worksheet S-2
Part II
Date/Time Prepared:
2/19/2016 2:55 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.	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			N	22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.			N	23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions			N	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.			N	25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.			N	26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.			N	27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.			N	28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions			N	29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.			N	30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.			N	31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.			N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.			Y	34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.			N	35.00
				Y/N	Date
				1.00	2.00
Home Office Costs					
36.00	Were home office costs claimed on the cost report?			Y	36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.			N	37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.			N	38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.			N	39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.			N	40.00
				1.00	2.00
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	JOHN		KREPPS	41.00
42.00	Enter the employer/company name of the cost report preparer.	SILVER CROSS HOSPITAL			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	815-300-7084		JKREPPS@SILVERCROSS.ORG	43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 140213	Period: From 10/01/2014 To 09/30/2015	Worksheet S-2 Part II Date/Time Prepared: 2/19/2016 2:55 am
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		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)	01/25/2016		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.	VICE PRESIDENT OF FINANCE		41.00
42.00	Enter the employer/company name of the cost report preparer.			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.			43.00

HFS Supplemental Information		Provider CCN: 140213	Period: From 10/01/2014 To 09/30/2015	Worksheet S-2 Part IX Date/Time Prepared: 2/19/2016 2:55 am	
			Title V	Title XIX	
			1.00	2.00	
TITLES V AND/OR XIX FOLLOWING MEDICARE					
1.00	Do Title V or XIX follow Medicare (Title XVIII) for the Interns and Residence post stepdown adjustments on W/S B, Part I, column 25? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.		Y	Y	1.00
2.00	Do Title V or XIX follow Medicare (Title XVIII) for the reporting of charges on W/S C, Part I (e.g. net of Physician's component)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.		Y	Y	2.00
3.00	Do Title V or XIX follow Medicare (Title XVIII) for the calculation of Observation Bed Cost on W/S D-1, Part IV, line 89? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.		Y	Y	3.00
			Inpatient	Outpatient	
			1.00	2.00	
CRITICAL ACCESS HOSPITALS					
4.00	Does Title V follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.		N	N	4.00
5.00	Does Title XIX follow Medicare (Title XVIII) for Critical Access Hospitals (CAH) being reimbursed 101% of cost? Enter Y or N in column 1 for inpatient and Y or N in column 2 for outpatient.		N	N	5.00
			Title V	Title XIX	
			1.00	2.00	
RCE DISALLOWANCE					
6.00	Do Title V or XIX follow Medicare and add back the RCE Disallowance on W/S C, Part I column 4? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.		Y	Y	6.00
PASS THROUGH COST					
7.00	Do Title V or XIX follow Medicare when cost reimbursed (payment system is "0") for worksheets D, parts I through IV? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.		Y	Y	7.00
RHC					
8.00	Do Title V & XIX impute 20% coinsurance (M-3 Line 16.04)? Enter Y/N in column 1 for Title V and Y/N in column 2 for Title XIX.		N	N	8.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 140213

Period:
From 10/01/2014
To 09/30/2015

Worksheet S-3
Part I
Date/Time Prepared:
2/19/2016 2:55 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	223	81,395	0.00	0	1.00
2.00 HMO and other (see instructions)						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					0	5.00
6.00 Hospital Adults & Peds. Swing Bed NF					0	6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)		223	81,395	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	28	10,220	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		251	91,615	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF	40.00	20	7,300		0	16.00
17.00 SUBPROVIDER - IRF	41.00	25	9,125		0	17.00
18.00 SUBPROVIDER	42.00	0	0		0	18.00
19.00 SKILLED NURSING FACILITY	44.00	0	0		0	19.00
20.00 NURSING FACILITY	45.00	0	0		0	20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	101.00				0	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	30.00					24.10
25.00 CMHC - CMHC	99.00				0	25.00
25.10 CMHC - CORF	99.10				0	25.10
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		296				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 140213

Period:
From 10/01/2014
To 09/30/2015

Worksheet S-3
Part I
Date/Time Prepared:
2/19/2016 2:55 am

Component	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII I	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
	6.00	7.00	8.00	9.00	10.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	26,985	6,948	56,354			1.00
2.00 HMO and other (see instructions)	4,504	1,166				2.00
3.00 HMO IPF Subprovider	7	0				3.00
4.00 HMO IRF Subprovider	431	41				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	26,985	6,948	56,354			7.00
8.00 INTENSIVE CARE UNIT	3,262	965	6,700			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		970	6,735			13.00
14.00 Total (see instructions)	30,247	8,883	69,789	0.00	1,601.88	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF	1,234	1,174	5,521	0.00	25.73	16.00
17.00 SUBPROVIDER - IRF	4,917	178	7,411	0.00	48.07	17.00
18.00 SUBPROVIDER	0	0	0	0.00	0.00	18.00
19.00 SKILLED NURSING FACILITY	0	0	0	0.00	0.00	19.00
20.00 NURSING FACILITY		0	0	0.00	0.00	20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	18,802	0	23,440	0.00	21.44	22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)	0	0	0			24.10
25.00 CMHC - CMHC	0	0	0	0.00	0.00	25.00
25.10 CMHC - CORF	0	0	0	0.00	0.00	25.10
26.00 RURAL HEALTH CLINIC	0	0	0	0.00	0.00	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00 Total (sum of lines 14-26)				0.00	1,697.12	27.00
28.00 Observation Bed Days		1,098	7,753			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	223	1,548			32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0			32.01
33.00 LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 140213

Period:
From 10/01/2014
To 09/30/2015

Worksheet S-3
Part I
Date/Time Prepared:
2/19/2016 2:55 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	7,484	3,374	18,679	1.00
2.00 HMO and other (see instructions)			1,064	42		2.00
3.00 HMO IPF Subprovider				0		3.00
4.00 HMO IRF Subprovider				0		4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	7,484	3,374	18,679	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF	0.00	0	164	381	907	16.00
17.00 SUBPROVIDER - IRF	0.00	0	389	15	606	17.00
18.00 SUBPROVIDER	0.00	0	0	0	0	18.00
19.00 SKILLED NURSING FACILITY	0.00					19.00
20.00 NURSING FACILITY	0.00					20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY	0.00					22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
24.10 HOSPICE (non-distinct part)						24.10
25.00 CMHC - CMHC	0.00					25.00
25.10 CMHC - CORF	0.00					25.10
26.00 RURAL HEALTH CLINIC	0.00					26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
32.01 Total ancillary labor & delivery room outpatient days (see instructions)						32.01
33.00 LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION			Provider CCN: 140213		Period: From 10/01/2014 To 09/30/2015		Worksheet S-3 Part II Date/Time Prepared: 2/19/2016 2:55 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	109,685,603	0	109,685,603	3,530,024.00	31.07	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	0	0	0	0.00	0.00	7.00
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7.01
8.00	Home office personnel		0	0	0	0.00	0.00	8.00
9.00	SNF	44.00	0	0	0	0.00	0.00	9.00
10.00	Excluded area salaries (see instructions)		7,045,670	0	7,045,670	212,192.00	33.20	10.00
OTHER WAGES & RELATED COSTS								
11.00	Contract labor: Direct Patient Care		2,043,273	0	2,043,273	39,580.00	51.62	11.00
12.00	Contract labor: Top level management and other management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract labor: Physician-Part A - Administrative		131,682	0	131,682	1,134.00	116.12	13.00
14.00	Home office salaries & wage-related costs		5,711,526	0	5,711,526	19,760.00	289.04	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)		32,223,447	0	32,223,447			17.00
18.00	Wage-related costs (other) (see instructions)		0	0	0			18.00
19.00	Excluded areas		2,211,963	0	2,211,963			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		0	0	0			21.00
22.00	Physician Part A - Administrative		0	0	0			22.00
22.01	Physician Part A - Teaching		0	0	0			22.01
23.00	Physician Part B		0	0	0			23.00
24.00	Wage-related costs (RHC/FQHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		0	0	0			25.00
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits Department	4.00	710,020	0	710,020	19,536.00	36.34	26.00
27.00	Administrative & General	5.00	15,476,464	-354,572	15,121,892	474,745.00	31.85	27.00
28.00	Administrative & General under contract (see inst.)		123,995	0	123,995	1,316.00	94.22	28.00
29.00	Maintenance & Repairs	6.00	0	0	0	0.00	0.00	29.00
30.00	Operation of Plant	7.00	2,798,938	0	2,798,938	112,032.00	24.98	30.00
31.00	Laundry & Linen Service	8.00	94,333	0	94,333	6,400.00	14.74	31.00
32.00	Housekeeping	9.00	2,173,211	0	2,173,211	152,304.00	14.27	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	1,812,836	-1,382,107	430,729	60,659.00	7.10	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	0	1,382,107	1,382,107	60,659.00	22.78	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	1,917,561	0	1,917,561	56,536.00	33.92	38.00
39.00	Central Services and Supply	14.00	1,375,593	-770,609	604,984	38,296.00	15.80	39.00
40.00	Pharmacy	15.00	2,937,362	0	2,937,362	65,216.00	45.04	40.00

HOSPITAL WAGE INDEX INFORMATION		Provider CCN: 140213		Period: From 10/01/2014 To 09/30/2015		Worksheet S-3 Part II Date/Time Prepared: 2/19/2016 2:55 am	
	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Sal ari es (from Worksheet A-6)	Adjus ted Sal ari es (col . 2 ± col . 3)	Paid Hours Related to Sal ari es in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
41.00	Medi cal Records & Medi cal Records Li brary	16.00 1,954,940	0	1,954,940	83,432.00	23.43	41.00
42.00	Soci al Servi ce	17.00 0	354,572	354,572	11,903.00	29.79	42.00
43.00	Other General Servi ce	18.00 0	0	0	0.00	0.00	43.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140213

Period:
From 10/01/2014
To 09/30/2015

Worksheet S-3
Part III
Date/Time Prepared:
2/19/2016 2:55 am

	Worksheet A Line Number	Amount Reported	Recl assi fi cation of Sal aries (from Worksheet A-6)	Adjusted Sal aries (col . 2 ± col . 3)	Paid Hours Related to Sal aries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
PART III - HOSPITAL WAGE INDEX SUMMARY							
1.00	Net salaries (see instructions)	109,809,598	0	109,809,598	3,531,340.00	31.10	1.00
2.00	Excluded area salaries (see instructions)	7,045,670	0	7,045,670	212,192.00	33.20	2.00
3.00	Subtotal salaries (line 1 minus line 2)	102,763,928	0	102,763,928	3,319,148.00	30.96	3.00
4.00	Subtotal other wages & related costs (see inst.)	7,886,481	0	7,886,481	60,474.00	130.41	4.00
5.00	Subtotal wage-related costs (see inst.)	32,223,447	0	32,223,447	0.00	31.36	5.00
6.00	Total (sum of lines 3 thru 5)	142,873,856	0	142,873,856	3,379,622.00	42.28	6.00
7.00	Total overhead cost (see instructions)	31,375,253	-770,609	30,604,644	1,143,034.00	26.77	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 140213	Period: From 10/01/2014 To 09/30/2015	Worksheet S-3 Part IV Date/Time Prepared: 2/19/2016 2:55 am
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions			0 1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution			0 2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)		4,399,301	3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)		0	4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration Fees		0	5.00
6.00	Legal/Accounting/Management Fees-Pension Plan		0	6.00
7.00	Employee Managed Care Program Administration Fees		0	7.00
HEALTH AND INSURANCE COST				
8.00	Health Insurance (Purchased or Self Funded)		15,726,135	8.00
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		694,606	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		124,936	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)		834,989	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		4,194,287	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		0	16.00
TAXES				
17.00	FICA-Employers Portion Only		8,101,337	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		124,567	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		235,252	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		34,435,410	24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 140213	Period: From 10/01/2014 To 09/30/2015	Worksheet S-3 Part V Date/Time Prepared: 2/19/2016 2:55 am
Cost Center Description		Contract Labor	Benefit Cost	
PART V - Contract Labor and Benefit Cost		1.00	2.00	
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	0	0	1.00
2.00	Hospital	0	0	2.00
3.00	Subprovider - IPF	0	0	3.00
4.00	Subprovider - IRF	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF	0	0	8.00
9.00	Hospital-Based NF	0	0	9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA	0	0	11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC	0	0	14.00
15.00	Hospital-Based Health Clinic FQHC	0	0	15.00
16.00	Hospital-Based-CMHC	0	0	16.00
16.10	Hospital-Based-CMHC 10	0	0	16.10
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

HOME HEALTH AGENCY STATISTICAL DATA		Provider CCN: 140213 Component CCN: 147452		Period: From 10/01/2014 To 09/30/2015		Worksheet S-4 Date/Time Prepared: 2/19/2016 2:55 am	
				Home Health Agency I		PPS	
				1.00			
0.00	County			WILL		0.00	
		Title V	Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3.00	4.00	5.00	
HOME HEALTH AGENCY STATISTICAL DATA							
1.00	Home Health Aide Hours	0	2,594	0	0	2,594	1.00
2.00	Unduplicated Census Count (see instructions)	0.00	1,026.00	21.00	276.00	1,323.00	2.00
				Number of Employees (Full Time Equivalent)			
		Enter the number of hours in your normal work week		Staff	Contract	Total	
		0		1.00	2.00	3.00	
HOME HEALTH AGENCY - NUMBER OF EMPLOYEES							
3.00	Administrator and Assistant Administrator(s)	40.00		7.36	0.00	7.36	3.00
4.00	Director(s) and Assistant Director(s)			0.00	0.00	0.00	4.00
5.00	Other Administrative Personnel			0.00	0.00	0.00	5.00
6.00	Direct Nursing Service			12.83	0.00	12.83	6.00
7.00	Nursing Supervisor			0.00	0.00	0.00	7.00
8.00	Physical Therapy Service			0.00	77.67	77.67	8.00
9.00	Physical Therapy Supervisor			0.00	0.00	0.00	9.00
10.00	Occupational Therapy Service			0.00	1.95	1.95	10.00
11.00	Occupational Therapy Supervisor			0.00	0.00	0.00	11.00
12.00	Speech Pathology Service			0.00	3.87	3.87	12.00
13.00	Speech Pathology Supervisor			0.00	0.00	0.00	13.00
14.00	Medical Social Service			0.06	4.68	4.74	14.00
15.00	Medical Social Service Supervisor			0.00	0.00	0.00	15.00
16.00	Home Health Aide			1.25	0.00	1.25	16.00
17.00	Home Health Aide Supervisor			0.00	0.00	0.00	17.00
18.00	Other (specify)			0.00	0.00	0.00	18.00
HOME HEALTH AGENCY CBSA CODES							
19.00	Enter in column 1 the number of CBSAs where you provided services during the cost reporting period.			1			19.00
20.00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20 contains the first code).	16974					20.00
		Full Episodes		LUPA Episodes	PEP Only Episodes	Total (cols. 1-4)	
		Without Outliers	With Outliers	3.00	4.00	5.00	
		1.00	2.00	3.00	4.00	5.00	
PPS ACTIVITY DATA							
21.00	Skilled Nursing Visits	8,037	943	184	387	9,551	21.00
22.00	Skilled Nursing Visit Charges	1,935,550	227,074	44,307	93,190	2,300,121	22.00
23.00	Physical Therapy Visits	5,316	271	20	226	5,833	23.00
24.00	Physical Therapy Visit Charges	1,198,772	61,192	4,516	51,031	1,315,511	24.00
25.00	Occupational Therapy Visits	1,440	126	3	79	1,648	25.00
26.00	Occupational Therapy Visit Charges	325,152	28,451	677	17,838	372,118	26.00
27.00	Speech Pathology Visits	219	43	0	23	285	27.00
28.00	Speech Pathology Visit Charges	52,483	10,305	0	5,512	68,300	28.00
29.00	Medical Social Service Visits	60	13	0	8	81	29.00
30.00	Medical Social Service Visit Charges	19,785	4,287	0	2,638	26,710	30.00
31.00	Home Health Aide Visits	1,154	210	6	34	1,404	31.00
32.00	Home Health Aide Visit Charges	169,927	30,923	884	5,007	206,741	32.00
33.00	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	16,226	1,606	213	757	18,802	33.00
34.00	Other Charges	0	0	0	0	0	34.00
35.00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	3,701,669	362,232	50,384	175,216	4,289,501	35.00
36.00	Total Number of Episodes (standard/non outlier)	805		71	38	914	36.00
37.00	Total Number of Outlier Episodes		35		5	40	37.00
38.00	Total Non-Routine Medical Supply Charges	51,428	4,521	3,672	1,759	61,380	38.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 140213	Period: From 10/01/2014 To 09/30/2015	Worksheet S-10 Date/Time Prepared: 2/19/2016 2:55 am
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			1.00		
Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided by line 202 column 8)		0.268932	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		29,390,000	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?		Y	3.00	
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?		Y	4.00	
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		0	5.00	
6.00	Medicaid charges		124,218,000	6.00	
7.00	Medicaid cost (line 1 times line 6)		33,406,195	7.00	
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)		4,016,195	8.00	
State Children's Health Insurance Program (SCHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone SCHIP		0	9.00	
10.00	Stand-alone SCHIP charges		0	10.00	
11.00	Stand-alone SCHIP cost (line 1 times line 10)		0	11.00	
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00	
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00	
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00	
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00	
Uncompensated care (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations		0	18.00	
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		4,016,195	19.00	
			Uninsured patients	Insured patients	
			1.00	2.00	
			Total (col. 1 + col. 2)		
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	11,363,641	3,300,615	14,664,256	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	3,056,047	887,641	3,943,688	21.00
22.00	Partial payment by patients approved for charity care	16,420	0	16,420	22.00
23.00	Cost of charity care (line 21 minus line 22)	3,039,627	887,641	3,927,268	23.00
			1.00		
24.00	Does the amount in line 20 column 2 include charges for patient days beyond a length of stay limit imposed on patients covered by Medicaid or other indigent care program?		N	24.00	
25.00	If line 24 is "yes," charges for patient days beyond an indigent care program's length of stay limit		0	25.00	
26.00	Total bad debt expense for the entire hospital complex (see instructions)		11,832,000	26.00	
27.00	Medicare bad debts for the entire hospital complex (see instructions)		923,521	27.00	
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)		10,908,479	28.00	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)		2,933,639	29.00	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)		6,860,907	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		10,877,102	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140213

Period:
From 10/01/2014
To 09/30/2015

Worksheet A
Date/Time Prepared:
2/19/2016 2:55 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassified (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		60,912,561	60,912,561	-26,866,638	34,045,923	1.00
2.00	00200		0	0	14,905,061	14,905,061	2.00
4.00	00400				0	35,939,277	4.00
5.00	00500	710,020	35,229,257	35,939,277	0	35,939,277	5.00
7.00	00700	15,476,464	37,017,356	52,493,820	8,797,956	61,291,776	7.00
8.00	00800	2,798,938	5,739,363	8,538,301	0	8,538,301	8.00
9.00	00900	94,333	-133,802	-39,469	0	-39,469	9.00
10.00	01000	2,173,211	1,243,845	3,417,056	0	3,417,056	10.00
11.00	01100	1,812,836	2,140,705	3,953,541	-3,014,182	939,359	11.00
13.00	01300	0	0	0	3,014,182	3,014,182	13.00
14.00	01400	1,917,561	38,259	1,955,820	-45	1,955,775	14.00
15.00	01500	1,375,593	1,457,300	2,832,893	-2,170,745	662,148	15.00
16.00	01600	2,937,362	12,791,835	15,729,197	-10,996,389	4,732,808	16.00
17.00	01700	1,954,940	1,118,469	3,073,409	0	3,073,409	17.00
23.00	02300	0	0	0	354,572	354,572	23.00
		287,627	350,374	638,001	-1,696	636,305	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	20,626,249	2,942,010	23,568,259	3,846,934	27,415,193	30.00
31.00	03100	5,353,682	1,183,865	6,537,547	-275,124	6,262,423	31.00
40.00	04000	1,755,893	371,759	2,127,652	27,070	2,154,722	40.00
41.00	04100	3,361,538	635,644	3,997,182	60,524	4,057,706	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	7,533,113	813,485	8,346,598	-6,172,850	2,173,748	43.00
44.00	04400	0	0	0	0	0	44.00
45.00	04500	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	8,145,568	30,196,215	38,341,783	-20,806,751	17,535,032	50.00
51.00	05100	1,187,553	61,771	1,249,324	-6,306	1,243,018	51.00
52.00	05200	0	761,902	761,902	2,922,139	3,684,041	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	7,550,268	11,119,325	18,669,593	-6,605,461	12,064,132	54.00
54.01	05401	1,083,881	184,188	1,268,069	-2,067	1,266,002	54.01
57.00	05700	1,060,718	934,981	1,995,699	-28,535	1,967,164	57.00
58.00	05800	564,412	484,970	1,049,382	-9	1,049,373	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	3,615,017	4,866,523	8,481,540	33,257	8,514,797	60.00
60.01	06001	0	0	0	0	0	60.01
63.00	06300	228,581	1,605,537	1,834,118	0	1,834,118	63.00
65.00	06500	1,421,108	260,106	1,681,214	86,068	1,767,282	65.00
65.01	06501	177,028	147,233	324,261	110,000	434,261	65.01
66.00	06600	1,069,878	404,558	1,474,436	-2,895	1,471,541	66.00
67.00	06700	2,245,055	482,838	2,727,893	-9,341	2,718,552	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	1,147,945	122,899	1,270,844	159,889	1,430,733	69.00
70.00	07000	225,835	21,086	246,921	708,988	955,909	70.00
71.00	07100	0	0	0	13,832,971	13,832,971	71.00
72.00	07200	0	0	0	16,842,908	16,842,908	72.00
73.00	07300	0	0	0	10,965,837	10,965,837	73.00
74.00	07400	381,871	138,624	520,495	11,575	532,070	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	497,938	185,720	683,658	23,699	707,357	90.00
90.01	09001	0	0	0	0	0	90.01
90.02	09002	0	0	0	0	0	90.02
90.03	09003	0	0	0	0	0	90.03
91.00	09100	6,530,673	1,655,073	8,185,746	318,850	8,504,596	91.00
91.01	09101	417,481	12,252	429,733	4,500	434,233	91.01
91.02	09102	324,821	6,257	331,078	-76,201	254,877	91.02
92.00	09200	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	0	0	0	0	0	94.00
99.00	09900	0	0	0	0	0	99.00
99.10	09910	0	0	0	0	0	99.10
101.00	10100	1,627,079	1,096,369	2,723,448	8,255	2,731,703	101.00
SPECIAL PURPOSE COST CENTERS							
109.00	10900	0	0	0	0	0	109.00
110.00	11000	0	0	0	0	0	110.00
111.00	11100	0	0	0	0	0	111.00
118.00		109,672,070	218,600,712	328,272,782	0	328,272,782	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	13,533	4	13,537	0	13,537	190.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140213

Period:
From 10/01/2014
To 09/30/2015

Worksheet A
Date/Time Prepared:
2/19/2016 2:55 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	CAP REL COSTS-BLDG & FIXT	-3,483,193	30,562,730	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	0	14,905,061	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	-73,627	35,865,650	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	-16,338,996	44,952,780	5.00
7.00	00700	OPERATION OF PLANT	628	8,538,929	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	-39,469	8.00
9.00	00900	HOUSEKEEPING	-95	3,416,961	9.00
10.00	01000	DIETARY	0	939,359	10.00
11.00	01100	CAFETERIA	-2,228,604	785,578	11.00
13.00	01300	NURSING ADMINISTRATION	0	1,955,775	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	-11,660	650,488	14.00
15.00	01500	PHARMACY	-42	4,732,766	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-2,969	3,070,440	16.00
17.00	01700	SOCIAL SERVICE	0	354,572	17.00
23.00	02300	PARAMED ED PRGM	-253,908	382,397	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-1,257,172	26,158,021	30.00
31.00	03100	INTENSIVE CARE UNIT	0	6,262,423	31.00
40.00	04000	SUBPROVIDER - I PF	-27,416	2,127,306	40.00
41.00	04100	SUBPROVIDER - I RF	-100,036	3,957,670	41.00
42.00	04200	SUBPROVIDER	0	0	42.00
43.00	04300	NURSERY	-3,227	2,170,521	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	45.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-11,400	17,523,632	50.00
51.00	05100	RECOVERY ROOM	0	1,243,018	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	3,684,041	52.00
53.00	05300	ANESTHESIOLOGY	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	3,145,247	15,209,379	54.00
54.01	05401	ULTRASOUND	0	1,266,002	54.01
57.00	05700	CT SCAN	0	1,967,164	57.00
58.00	05800	MRI	0	1,049,373	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	-27,820	8,486,977	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	-24	1,834,094	63.00
65.00	06500	RESPIRATORY THERAPY	-77,087	1,690,195	65.00
65.01	06501	SLEEP LAB	-110,000	324,261	65.01
66.00	06600	PHYSICAL THERAPY	0	1,471,541	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	2,718,552	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	-193,503	1,237,230	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	-720,017	235,892	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	13,832,971	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	16,842,908	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	10,965,837	73.00
74.00	07400	RENAL DIALYSIS	-6,466	525,604	74.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	-45,442	661,915	90.00
90.01	09001	HOMER GLEN LAB	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0	0	90.03
91.00	09100	EMERGENCY	-684,583	7,820,013	91.00
91.01	09101	OP MENTAL HEALTH	-4,770	429,463	91.01
91.02	09102	DIABETES CENTER	-3,394	251,483	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
OTHER REIMBURSABLE COST CENTERS					
94.00	09400	HOME PROGRAM DIALYSIS	0	0	94.00
99.00	09900	CMHC	0	0	99.00
99.10	09910	CORF	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	2,731,703	101.00
SPECIAL PURPOSE COST CENTERS					
109.00	10900	PANCREAS ACQUISITION	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	-22,519,576	305,753,206	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13,537	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	192.00
200.00		TOTAL (SUM OF LINES 118-199)	-22,519,576	305,766,743	200.00

COST CENTERS USED IN COST REPORT		Provider CCN: 140213	Period: From 10/01/2014 To 09/30/2015	Worksheet Non-CMS W Date/Time Prepared: 2/19/2016 2:55 am
Cost Center Description		CMS Code	Standard Label For Non-Standard Codes	
		1.00	2.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	00100		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	00200		2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	00400		4.00
5.00	ADMINISTRATIVE & GENERAL	00500		5.00
7.00	OPERATION OF PLANT	00700		7.00
8.00	LAUNDRY & LINEN SERVICE	00800		8.00
9.00	HOUSEKEEPING	00900		9.00
10.00	DIETARY	01000		10.00
11.00	CAFETERIA	01100		11.00
13.00	NURSING ADMINISTRATION	01300		13.00
14.00	CENTRAL SERVICES & SUPPLY	01400		14.00
15.00	PHARMACY	01500		15.00
16.00	MEDICAL RECORDS & LIBRARY	01600		16.00
17.00	SOCIAL SERVICE	01700		17.00
23.00	PARAMED ED PRGM	02300		23.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	ADULTS & PEDIATRICS	03000		30.00
31.00	INTENSIVE CARE UNIT	03100		31.00
40.00	SUBPROVIDER - IPF	04000		40.00
41.00	SUBPROVIDER - IRF	04100		41.00
42.00	SUBPROVIDER	04200		42.00
43.00	NURSERY	04300		43.00
44.00	SKILLED NURSING FACILITY	04400		44.00
45.00	NURSING FACILITY	04500		45.00
ANCILLARY SERVICE COST CENTERS				
50.00	OPERATING ROOM	05000		50.00
51.00	RECOVERY ROOM	05100		51.00
52.00	DELIVERY ROOM & LABOR ROOM	05200		52.00
53.00	ANESTHESIOLOGY	05300		53.00
54.00	RADIOLOGY-DIAGNOSTIC	05400		54.00
54.01	ULTRASOUND	05401		54.01
57.00	CT SCAN	05700		57.00
58.00	MRI	05800		58.00
59.00	CARDIAC CATHETERIZATION	05900		59.00
60.00	LABORATORY	06000		60.00
60.01	BLOOD LABORATORY	06001		60.01
63.00	BLOOD STORING, PROCESSING & TRANS.	06300		63.00
65.00	RESPIRATORY THERAPY	06500		65.00
65.01	SLEEP LAB	06501		65.01
66.00	PHYSICAL THERAPY	06600		66.00
67.00	OCCUPATIONAL THERAPY	06700		67.00
68.00	SPEECH PATHOLOGY	06800		68.00
69.00	ELECTROCARDIOLOGY	06900		69.00
70.00	ELECTROENCEPHALOGRAPHY	07000		70.00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENT	07100		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	07200		72.00
73.00	DRUGS CHARGED TO PATIENTS	07300		73.00
74.00	RENAL DIALYSIS	07400		74.00
OUTPATIENT SERVICE COST CENTERS				
88.00	RURAL HEALTH CLINIC	08800		88.00
89.00	FEDERALLY QUALIFIED HEALTH CENTER	08900		89.00
90.00	CLINIC	09000		90.00
90.01	HOMER GLEN LAB	09001		90.01
90.02	HOMER GLEN FEC	09002		90.02
90.03	WOMEN'S HEALTH	09003		90.03
91.00	EMERGENCY	09100		91.00
91.01	OP MENTAL HEALTH	09101		91.01
91.02	DIABETES CENTER	09102		91.02
92.00	OBSERVATION BEDS (NON-DISTINCT PART	09200		92.00
OTHER REIMBURSABLE COST CENTERS				
94.00	HOME PROGRAM DIALYSIS	09400		94.00
99.00	CMHC	09900		99.00
99.10	CORF	09910		99.10
101.00	HOME HEALTH AGENCY	10100		101.00
SPECIAL PURPOSE COST CENTERS				
109.00	PANCREAS ACQUISITION	10900		109.00
110.00	INTESTINAL ACQUISITION	11000		110.00
111.00	ISLET ACQUISITION	11100		111.00
118.00	SUBTOTALS (SUM OF LINES 1-117)			118.00
NONREIMBURSABLE COST CENTERS				
190.00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	19000		190.00

COST CENTERS USED IN COST REPORT		Provider CCN: 140213	Period: From 10/01/2014 To 09/30/2015	Worksheet Non-CMS W Date/Time Prepared: 2/19/2016 2:55 am
Cost Center Description		CMS Code	Standard Label For Non-Standard Codes	
		1.00	2.00	
192.00	PHYSICIANS' PRIVATE OFFICES	19200		192.00
200.00	TOTAL (SUM OF LINES 118-199)			200.00

RECLASSIFICATIONS

Provider CCN: 140213

Period:
From 10/01/2014
To 09/30/2015

Worksheet A-6
Date/Time Prepared:
2/19/2016 2:55 am

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - STERILE PROCESSING					
1.00	ADULTS & PEDIATRICS	30.00	10,789	15,676	1.00
2.00	OPERATING ROOM	50.00	690,466	1,003,263	2.00
3.00	DELIVERY ROOM & LABOR ROOM	52.00	48,548	70,542	3.00
4.00	RADIOLOGY-DIAGNOSTIC	54.00	5,394	7,838	4.00
5.00	CLINIC	90.00	3,082	4,479	5.00
6.00	EMERGENCY	91.00	12,330	17,915	6.00
	O		770,609	1,119,713	
C - CAPITAL INSURANCE					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	187,043	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	204,577	2.00
	O		0	391,620	
D - CHARGEABLE DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	10,965,837	1.00
	O		0	10,965,837	
E - MALPRACTICE INSURANCE					
1.00	ADMINISTRATIVE & GENERAL	5.00	0	11,757,000	1.00
	O		0	11,757,000	
F - DEPRECIATION					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	14,718,018	1.00
	O		0	14,718,018	
G - PHYSICIAN FEES					
1.00	ADULTS & PEDIATRICS	30.00	0	1,257,028	1.00
2.00	INTENSIVE CARE UNIT	31.00	0	16,750	2.00
3.00	SUBPROVIDER - IPF	40.00	0	27,400	3.00
4.00	SUBPROVIDER - IRF	41.00	0	100,000	4.00
5.00	OPERATING ROOM	50.00	0	15,000	5.00
6.00	LABORATORY	60.00	0	34,000	6.00
7.00	RESPIRATORY THERAPY	65.00	0	88,332	7.00
8.00	SLEEP LAB	65.01	0	110,000	8.00
9.00	ELECTROCARDIOLOGY	69.00	0	160,000	9.00
10.00	ELECTROENCEPHALOGRAPHY	70.00	0	720,017	10.00
11.00	RENAL DIALYSIS	74.00	0	12,600	11.00
12.00	CLINIC	90.00	0	45,424	12.00
13.00	EMERGENCY	91.00	0	362,150	13.00
14.00	OP MENTAL HEALTH	91.01	0	4,500	14.00
15.00	DIABETES CENTER	91.02	0	5,000	15.00
16.00	HOME HEALTH AGENCY	101.00	0	35,000	16.00
	O		0	2,993,201	
H - LABOR AND DELIVERY					
1.00	ADULTS & PEDIATRICS	30.00	3,001,800	0	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	3,153,707	0	2.00
	O		6,155,507	0	
I - SOCIAL SERVICES					
1.00	SOCIAL SERVICE	17.00	354,572	0	1.00
	O		354,572	0	
K - CHARGEABLE SUPPLIES					
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	13,832,971	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	184,152	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0.00	0	0	11.00
12.00		0.00	0	0	12.00
13.00		0.00	0	0	13.00
14.00		0.00	0	0	14.00
15.00		0.00	0	0	15.00
16.00		0.00	0	0	16.00
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19.00		0.00	0	0	19.00
20.00		0.00	0	0	20.00
21.00		0.00	0	0	21.00
22.00		0.00	0	0	22.00
23.00		0.00	0	0	23.00
24.00		0.00	0	0	24.00
25.00		0.00	0	0	25.00
26.00		0.00	0	0	26.00

RECLASSIFICATIONS

Provider CCN: 140213

Period:
From 10/01/2014
To 09/30/2015

Worksheet A-6

Date/Time Prepared:
2/19/2016 2:55 am

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
27.00		0.00	0	0	27.00
			0	14,017,123	
L - DIABETES MANAGEMENT					
1.00	ADULTS & PEDIATRICS	30.00	79,567	1,615	1.00
			79,567	1,615	
M - DIETARY RECLASS					
1.00	CAFETERIA	11.00	1,382,107	1,632,075	1.00
			1,382,107	1,632,075	
N - IMPLANTABLE DEVICES					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	16,842,908	1.00
2.00		0.00	0	0	2.00
			0	16,842,908	
500.00	Grand Total: Increases		8,742,362	74,439,110	500.00

RECLASSIFICATIONS

Provider CCN: 140213

Period:
From 10/01/2014
To 09/30/2015

Worksheet A-6
Date/Time Prepared:
2/19/2016 2:55 am

		Decreases					
Cost Center		Line #	Salary	Other	Wkst. A-7 Ref.		
6.00		7.00	8.00	9.00	10.00		
A - STERILE PROCESSING							
1.00	CENTRAL SERVICES & SUPPLY	14.00	770,609	1,119,713	9		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
	O		770,609	1,119,713			
C - CAPITAL INSURANCE							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	391,620	9		1.00
2.00		0.00	0	0	0		2.00
	O		0	391,620			
D - CHARGEABLE DRUGS							
1.00	PHARMACY	15.00	0	10,965,837	0		1.00
	O		0	10,965,837			
E - MALPRACTICE INSURANCE							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	11,757,000	9		1.00
	O		0	11,757,000			
F - DEPRECIATION							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	14,718,018	9		1.00
	O		0	14,718,018			
G - PHYSICIAN FEES							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	2,993,201	9		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
9.00		0.00	0	0	0		9.00
10.00		0.00	0	0	0		10.00
11.00		0.00	0	0	0		11.00
12.00		0.00	0	0	0		12.00
13.00		0.00	0	0	0		13.00
14.00		0.00	0	0	0		14.00
15.00		0.00	0	0	0		15.00
16.00		0.00	0	0	0		16.00
	O		0	2,993,201			
H - LABOR AND DELIVERY							
1.00	NURSERY	43.00	6,155,507	0	0		1.00
2.00		0.00	0	0	0		2.00
	O		6,155,507	0			
I - SOCIAL SERVICES							
1.00	ADMINISTRATIVE & GENERAL	5.00	354,572	0	0		1.00
	O		354,572	0			
K - CHARGEABLE SUPPLIES							
1.00	NURSING ADMINISTRATION	13.00	0	45	0		1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	280,423	0		2.00
3.00	PHARMACY	15.00	0	30,552	0		3.00
4.00	PARAMED ED PRGM	23.00	0	1,696	0		4.00
5.00	ADULTS & PEDIATRICS	30.00	0	519,541	0		5.00
6.00	INTENSIVE CARE UNIT	31.00	0	291,874	0		6.00
7.00	SUBPROVIDER - IPF	40.00	0	330	0		7.00
8.00	SUBPROVIDER - IRF	41.00	0	39,476	0		8.00
9.00	NURSERY	43.00	0	17,343	0		9.00
10.00	OPERATING ROOM	50.00	0	9,104,678	0		10.00
11.00	RECOVERY ROOM	51.00	0	6,306	0		11.00
12.00	DELIVERY ROOM & LABOR ROOM	52.00	0	350,658	0		12.00
13.00	RADIOLOGY-DIAGNOSTIC	54.00	0	3,186,587	0		13.00
14.00	ULTRASOUND	54.01	0	2,067	0		14.00
15.00	CT SCAN	57.00	0	28,535	0		15.00
16.00	MRI	58.00	0	9	0		16.00
17.00	LABORATORY	60.00	0	743	0		17.00
18.00	RESPIRATORY THERAPY	65.00	0	2,264	0		18.00
19.00	PHYSICAL THERAPY	66.00	0	2,895	0		19.00
20.00	OCCUPATIONAL THERAPY	67.00	0	9,341	0		20.00
21.00	ELECTROCARDIOLOGY	69.00	0	111	0		21.00
22.00	ELECTROENCEPHALOGRAPHY	70.00	0	11,029	0		22.00
23.00	RENAL DIALYSIS	74.00	0	1,025	0		23.00
24.00	CLINIC	90.00	0	29,286	0		24.00
25.00	EMERGENCY	91.00	0	73,545	0		25.00
26.00	HOME HEALTH AGENCY	101.00	0	26,745	0		26.00
27.00	DIABETES CENTER	91.02	0	19	0		27.00

RECLASSIFICATIONS

Provider CCN: 140213

Period:
From 10/01/2014
To 09/30/2015

Worksheet A-6

Date/Time Prepared:
2/19/2016 2:55 am

Decreases						
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.	
	6.00	7.00	8.00	9.00	10.00	
	0		0	14,017,123		
L - DIABETES MANAGEMENT						
1.00	DIABETES CENTER	91.02	79,567	1,615	0	1.00
	0		79,567	1,615		
M - DIETARY RECLASS						
1.00	DIETARY	10.00	1,382,107	1,632,075	0	1.00
	0		1,382,107	1,632,075		
N - IMPLANTABLE DEVICES						
1.00	RADIOLOGY-DIAGNOSTIC	54.00	0	3,432,106	0	1.00
2.00	OPERATING ROOM	50.00	0	13,410,802	0	2.00
	0		0	16,842,908		
500.00	Grand Total: Decreases		8,742,362	74,439,110		500.00

RECLASSIFICATIONS

Provider CCN: 140213

Period:
From 10/01/2014
To 09/30/2015

Worksheet A-6
Non-CMS Worksheet
Date/Time Prepared:
2/19/2016 2:55 am

Increases					Decreases				
Cost Center	Line #	Salary	Other	Cost Center	Line #	Salary	Other		
2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00		
A - STERILE PROCESSING									
1.00	ADULTS & PEDIATRICS	30.00	10,789	15,676	CENTRAL SERVICES & SUPPLY	14.00	770,609	1,119,713	1.00
2.00	OPERATING ROOM	50.00	690,466	1,003,263		0.00	0	0	2.00
3.00	DELIVERY ROOM & LABOR ROOM	52.00	48,548	70,542		0.00	0	0	3.00
4.00	RADIOLOGY-DIAGNOSTIC CLINIC	54.00	5,394	7,838		0.00	0	0	4.00
5.00	CLINIC	90.00	3,082	4,479		0.00	0	0	5.00
6.00	EMERGENCY	91.00	12,330	17,915		0.00	0	0	6.00
0			770,609	1,119,713	0		770,609	1,119,713	
C - CAPITAL INSURANCE									
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	187,043	CAP REL COSTS-BLDG & FIXT	1.00	0	391,620	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	204,577		0.00	0	0	2.00
0			0	391,620	0		0	391,620	
D - CHARGEABLE DRUGS									
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	10,965,837	PHARMACY	15.00	0	10,965,837	1.00
0			0	10,965,837	0		0	10,965,837	
E - MALPRACTICE INSURANCE									
1.00	ADMINISTRATIVE & GENERAL	5.00	0	11,757,000	CAP REL COSTS-BLDG & FIXT	1.00	0	11,757,000	1.00
0			0	11,757,000	0		0	11,757,000	
F - DEPRECIATION									
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	14,718,018	CAP REL COSTS-BLDG & FIXT	1.00	0	14,718,018	1.00
0			0	14,718,018	0		0	14,718,018	
G - PHYSICIAN FEES									
1.00	ADULTS & PEDIATRICS	30.00	0	1,257,028	ADMINISTRATIVE & GENERAL	5.00	0	2,993,201	1.00
2.00	INTENSIVE CARE UNIT	31.00	0	16,750		0.00	0	0	2.00
3.00	SUBPROVIDER - IPF	40.00	0	27,400		0.00	0	0	3.00
4.00	SUBPROVIDER - IRF	41.00	0	100,000		0.00	0	0	4.00
5.00	OPERATING ROOM	50.00	0	15,000		0.00	0	0	5.00
6.00	LABORATORY	60.00	0	34,000		0.00	0	0	6.00
7.00	RESPIRATORY THERAPY	65.00	0	88,332		0.00	0	0	7.00
8.00	SLEEP LAB	65.01	0	110,000		0.00	0	0	8.00
9.00	ELECTROCARDIOLOGY	69.00	0	160,000		0.00	0	0	9.00
10.00	ELECTROENCEPHALOGRAPHY	70.00	0	720,017		0.00	0	0	10.00
11.00	RENAL DIALYSIS	74.00	0	12,600		0.00	0	0	11.00
12.00	CLINIC	90.00	0	45,424		0.00	0	0	12.00
13.00	EMERGENCY	91.00	0	362,150		0.00	0	0	13.00
14.00	OP MENTAL HEALTH	91.01	0	4,500		0.00	0	0	14.00
15.00	DIABETES CENTER	91.02	0	5,000		0.00	0	0	15.00
16.00	HOME HEALTH AGENCY	101.00	0	35,000		0.00	0	0	16.00
0			0	2,993,201	0		0	2,993,201	
H - LABOR AND DELIVERY									
1.00	ADULTS & PEDIATRICS	30.00	3,001,800	0	NURSERY	43.00	6,155,507	0	1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	3,153,707	0		0.00	0	0	2.00
0			6,155,507	0	0		6,155,507	0	
I - SOCIAL SERVICES									
1.00	SOCIAL SERVICE	17.00	354,572	0	ADMINISTRATIVE & GENERAL	5.00	354,572	0	1.00
0			354,572	0	0		354,572	0	
K - CHARGEABLE SUPPLIES									
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	13,832,971	NURSING ADMINISTRATION	13.00	0	45	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	184,152	CENTRAL SERVICES & SUPPLY	14.00	0	280,423	2.00
3.00		0.00	0	0	PHARMACY	15.00	0	30,552	3.00
4.00		0.00	0	0	PARAMED PRGM	23.00	0	1,696	4.00
5.00		0.00	0	0	ADULTS & PEDIATRICS	30.00	0	519,541	5.00
6.00		0.00	0	0	INTENSIVE CARE UNIT	31.00	0	291,874	6.00
7.00		0.00	0	0	SUBPROVIDER - IPF	40.00	0	330	7.00
8.00		0.00	0	0	SUBPROVIDER - IRF	41.00	0	39,476	8.00
9.00		0.00	0	0	NURSERY	43.00	0	17,343	9.00
10.00		0.00	0	0	OPERATING ROOM	50.00	0	9,104,678	10.00
11.00		0.00	0	0	RECOVERY ROOM	51.00	0	6,306	11.00
12.00		0.00	0	0	DELIVERY ROOM & LABOR ROOM	52.00	0	350,658	12.00
13.00		0.00	0	0	RADIOLOGY-DIAGNOSTIC	54.00	0	3,186,587	13.00
14.00		0.00	0	0	ULTRASOUND	54.01	0	2,067	14.00

Provider CCN: 140213

Period:
From 10/01/2014
To 09/30/2015

Worksheet A-6
Non-CMS Worksheet
Date/Time Prepared:
2/19/2016 2:55 am

	Increases				Decreases				
	Cost Center	Line #	Salary	Other	Cost Center	Line #	Salary	Other	
	2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00	
15.00		0.00	0		0 CT SCAN	57.00	0	28,535	15.00
16.00		0.00	0		0 MRI	58.00	0	9	16.00
17.00		0.00	0		0 LABORATORY	60.00	0	743	17.00
18.00		0.00	0		0 RESPIRATORY THERAPY	65.00	0	2,264	18.00
19.00		0.00	0		0 PHYSICAL THERAPY	66.00	0	2,895	19.00
20.00		0.00	0		0 OCCUPATIONAL THERAPY	67.00	0	9,341	20.00
21.00		0.00	0		0 ELECTROCARDIOLOGY	69.00	0	111	21.00
22.00		0.00	0		0 ELECTROENCEPHALOGRAPHY	70.00	0	11,029	22.00
23.00		0.00	0		0 RENAL DIALYSIS	74.00	0	1,025	23.00
24.00		0.00	0		0 CLINIC	90.00	0	29,286	24.00
25.00		0.00	0		0 EMERGENCY	91.00	0	73,545	25.00
26.00		0.00	0		0 HOME HEALTH AGENCY	101.00	0	26,745	26.00
27.00		0.00	0		0 DIABETES CENTER	91.02	0	19	27.00
	0		0	14,017,123	0		0	14,017,123	
L - DIABETES MANAGEMENT									
1.00	ADULTS & PEDIATRICS	30.00	79,567	1,615	DIABETES CENTER	91.02	79,567	1,615	1.00
	0		79,567	1,615	0		79,567	1,615	
M - DIETARY RECLASS									
1.00	CAFETERIA	11.00	1,382,107	1,632,075	DIETARY	10.00	1,382,107	1,632,075	1.00
	0		1,382,107	1,632,075	0		1,382,107	1,632,075	
N - IMPLANTABLE DEVICES									
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	16,842,908	RADIOLOGY-DIAGNOSTIC	54.00	0	3,432,106	1.00
2.00		0.00	0		OPERATING ROOM	50.00	0	13,410,802	2.00
	0		0	16,842,908	0		0	16,842,908	
500.00	Grand Total: Increases		8,742,362	74,439,110	Grand Total: Decreases		8,742,362	74,439,110	500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140213

Period:
From 10/01/2014
To 09/30/2015

Worksheet A-7
Part I
Date/Time Prepared:
2/19/2016 2:55 am

	Beginning Balances	Acquisitions			Disposals and Retirements	
		Purchases	Donation	Total		
	1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	14,801,161	0	0	0	1.00
2.00	Land Improvements	13,585,486	0	0	0	2.00
3.00	Buildings and Fixtures	333,260,750	55	0	55	3.00
4.00	Building Improvements	2,608,989	541,794	0	541,794	4.00
5.00	Fixed Equipment	13,180,425	533,937	0	533,937	5.00
6.00	Movable Equipment	193,347,577	7,674,225	0	7,674,225	6.00
7.00	HIT designated Assets	0	0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	570,784,388	8,750,011	0	8,750,011	8.00
9.00	Reconciling Items	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	570,784,388	8,750,011	0	8,750,011	10.00
	Ending Balance		Fully Depreciated Assets			
		6.00	7.00			
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES						
1.00	Land	14,801,161	0			1.00
2.00	Land Improvements	13,585,486	0			2.00
3.00	Buildings and Fixtures	333,260,805	0			3.00
4.00	Building Improvements	3,150,783	0			4.00
5.00	Fixed Equipment	13,714,362	0			5.00
6.00	Movable Equipment	201,021,802	0			6.00
7.00	HIT designated Assets	0	0			7.00
8.00	Subtotal (sum of lines 1-7)	579,534,399	0			8.00
9.00	Reconciling Items	0	0			9.00
10.00	Total (line 8 minus line 9)	579,534,399	0			10.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140213

Period:
From 10/01/2014
To 09/30/2015

Worksheet A-7
Part II
Date/Time Prepared:
2/19/2016 2:55 am

Cost Center Description		SUMMARY OF CAPITAL					
		Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FIXT	26,092,459	114,286	22,342,733	12,312,009	51,074	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	26,092,459	114,286	22,342,733	12,312,009	51,074	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	60,912,561				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	60,912,561				3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140213

Period:
From 10/01/2014
To 09/30/2015

Worksheet A-7
Part III
Date/Time Prepared:
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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	378,512,596	0	378,512,596	0.653132	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	201,021,802	0	201,021,802	0.346868	0	2.00
3.00	Total (sum of lines 1-2)	579,534,398	0	579,534,398	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	-1,410,110	114,286	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	14,905,061	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	13,494,951	114,286	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	19,495,471	12,312,009	51,074	0	30,562,730	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	14,905,061	2.00
3.00	Total (sum of lines 1-2)	19,495,471	12,312,009	51,074	0	45,467,791	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 140213

Period:
From 10/01/2014
To 09/30/2015

Worksheet A-8

Date/Time Prepared:
2/19/2016 2:55 am

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 #		
			3.00	4.00		
	1.00	2.00		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	-4,060,716				0 10.00
11.00 Sale of scrap, waste, etc. (chapter 23)			0		0.00	0 11.00
12.00 Related organization transactions (chapter 10)	A-8-1	1,193,574				0 12.00
13.00 Laundry and linen service			0		0.00	0 13.00
14.00 Cafeteria-employees and guests			0		0.00	0 14.00
15.00 Rental of quarters to employee and others			0		0.00	0 15.00
16.00 Sale of medical and surgical supplies to other than patients			0		0.00	0 16.00
17.00 Sale of drugs to other than patients			0		0.00	0 17.00
18.00 Sale of medical records and abstracts			0		0.00	0 18.00
19.00 Nursing school (tuition, fees, books, etc.)			0		0.00	0 19.00
20.00 Vending machines			0		0.00	0 20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)			0		0.00	0 21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments			0		0.00	0 22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		0	RESPIRATORY THERAPY	65.00	23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		0	PHYSICAL THERAPY	66.00	24.00
25.00 Utilization review - physicians' compensation (chapter 21)			0	*** Cost Center Deleted ***	114.00	25.00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT			0	CAP REL COSTS-BLDG & FIXT	1.00	0 26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP			0	CAP REL COSTS-MVBLE EQUIP	2.00	0 27.00
28.00 Non-physician Anesthetist			0	*** Cost Center Deleted ***	19.00	28.00
29.00 Physicians' assistant			0		0.00	0 29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		0	OCCUPATIONAL THERAPY	67.00	30.00
30.99 Hospice (non-distinct) (see instructions)			0	ADULTS & PEDIATRICS	30.00	30.99
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		0	SPEECH PATHOLOGY	68.00	31.00
32.00 CAH HIT Adjustment for Depreciation and Interest			0		0.00	0 32.00
33.00 OTHER ADJUSTMENTS (SPECIFY) (3)			0		0.00	0 33.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 140213

Period:
From 10/01/2014
To 09/30/2015

Worksheet A-8

Date/Time Prepared:
2/19/2016 2:55 am

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	
33.01 1996 DSR INTEXP. ADD ON	A	14,351	CAP REL COSTS-BLDG & FIXT	1.00	9 33.01	
33.02 OTHER REVENUE-CENTRAL SUPPLY	B	-11,660	CENTRAL SERVICES & SUPPLY	14.00	0 33.02	
33.03 TELEPHONE BENEFITS	B	-18,513	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 33.03	
38.00 PHYSICIANS	A	-395,126	ADMINISTRATIVE & GENERAL	5.00	0 38.00	
39.00 CONTRIBUTIONS EXPENSE	B	-103,318	ADMINISTRATIVE & GENERAL	5.00	9 39.00	
40.00 BAD DEBTS	A	1,304,273	ADMINISTRATIVE & GENERAL	5.00	0 40.00	
41.00 AHA & IHA DUES-POLITICAL LOBBY	B	-48,887	ADMINISTRATIVE & GENERAL	5.00	0 41.00	
42.00 OTHER REV A & G	A	-2,070,904	ADMINISTRATIVE & GENERAL	5.00	0 42.00	
43.00 TELEPHONE COSTS	A	-66,228	ADMINISTRATIVE & GENERAL	5.00	0 43.00	
44.00 COMMUNITY RELATIONS	A	-1,253,489	ADMINISTRATIVE & GENERAL	5.00	0 44.00	
45.00 ADVERTISING ADMIN (EXPENSE ACCT# 510)	B	-12,814	ADMINISTRATIVE & GENERAL	5.00	0 45.00	
45.01 OTHER REV-EMPLOYEE BENEFITS	B	-55,114	EMPLOYEE BENEFITS DEPARTMENT	4.00	0 45.01	
45.02 OTHER REV-OPERATION & PLANT	B	628	OPERATION OF PLANT	7.00	0 45.02	
45.04 OTHER REV-CAFÉ -EMP & GUESTS	B	-2,224,389	CAFETERIA	11.00	0 45.04	
45.05 OTHER REV-VENDING MACHINES	B	-4,215	CAFETERIA	11.00	0 45.05	
45.06 OTHER REV-PARAMED ED PROGRAM	B	-253,908	PARAMED ED PRGM	23.00	0 45.06	
45.07 OTHER REV-A & P	B	-144	ADULTS & PEDIATRICS	30.00	0 45.07	
45.08 OTHER REV-PSYCH	B	-270	OP MENTAL HEALTH	91.01	0 45.08	
45.09 OTHER REV-NURSERY	B	-3,227	NURSERY	43.00	0 45.09	
45.11 OTHER REV-RADIOLOGY	B	-9,420	RADIOLOGY-DIAGNOSTIC	54.00	0 45.11	
45.12 OTHER REV-LAB	B	-42	LABORATORY	60.00	0 45.12	
45.13 OTHER REV-CARDIAC CATH	B	-33,503	ELECTROCARDIOLOGY	69.00	0 45.13	
45.15 OTHER REV-ER	B	-362,303	EMERGENCY	91.00	0 45.15	
45.16 OTHER REV-DIABETES	B	-950	DIABETES CENTER	91.02	0 45.16	
45.19 INVESTMENT INCOME	B	-2,847,262	CAP REL COSTS-BLDG & FIXT	1.00	11 45.19	
45.20 OTHER REV-MED REC	B	-2,969	MEDICAL RECORDS & LIBRARY	16.00	0 45.20	
45.22 OTHER REV-PSYCH	A	-16	SUBPROVIDER - IPF	40.00	0 45.22	
45.24 OTHER REV-ENVIRONMENTAL SERVICES	B	-95	HOUSEKEEPING	9.00	0 45.24	
45.25 ADMINISTRATIVE MI SC. EXPENSE	B	-173,545	ADMINISTRATIVE & GENERAL	5.00	0 45.25	
45.27 OTHER REV-PHARMACY	B	-42	PHARMACY	15.00	0 45.27	
45.32 OTHER REV-CLINIC	B	-36	SUBPROVIDER - IRF	41.00	0 45.32	
45.34 OTHER REV-BLOOD	A	-18	CLINIC	90.00	0 45.34	
45.35 OTHER REV-HOMER FEC	B	-24	BLOOD STORING, PROCESSING & TRANS.	63.00	0 45.35	
46.00 PROVIDER TAX ASSESSMENT IN A&G	B	-10,368,973	ADMINISTRATIVE & GENERAL	5.00	0 46.00	
46.01 OTHER REV - CAPITAL EXPENSE	B	-650,282	CAP REL COSTS-BLDG & FIXT	1.00	9 46.01	
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		-22,519,576			50.00	

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

(2) Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

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

Provider CCN: 140213

Period: From 10/01/2014 To 09/30/2015

Worksheet A-8-1

Date/Time Prepared: 2/19/2016 2:55 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 HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	MANAGEMENT FEE	6,294,056	8,255,149 1.00
2.00	54.00	RADIOLOGY-DIAGNOSTIC	JOINT VENTURE OPERATING EXPE	3,154,667	0 2.00
3.00	0.00			0	0 3.00
4.00	0.00			0	0 4.00
4.01	0.00			0	0 4.01
4.02	0.00			0	0 4.02
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			9,448,723	8,255,149 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	G	SILVER CROSS HO	100.00	SILVER CROSS HO	100.00	6.00
7.00	C	UCMS/SCH ONC JV	60.00	UCMS/SCH ONC JV	60.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9.00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or non-financial) specify:	FINANCIAL				100.00

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

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

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

Provider CCN: 140213

Period:
From 10/01/2014
To 09/30/2015

Worksheet A-8-1

Date/Time Prepared:
2/19/2016 2:55 am

	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.		
	6.00	7.00		
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00	-1,961,093	0		1.00
2.00	3,154,667	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
4.01	0	0		4.01
4.02	0	0		4.02
5.00	1,193,574			5.00

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

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

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

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

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

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 140213

Period:
From 10/01/2014
To 09/30/2015

Worksheet A-8-2

Date/Time Prepared:
2/19/2016 2:55 am

	Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	Provider Component	RCE Amount	Physician/Provider Component Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	1,188,892	1,188,892	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	1,257,028	1,257,028	0	0	0	2.00
3.00	31.00	INTENSIVE CARE UNIT	16,750	0	16,750	177,200	336	3.00
4.00	40.00	SUBPROVIDER - IPF	27,400	27,400	0	154,100	0	4.00
5.00	41.00	SUBPROVIDER - IRF	100,000	100,000	0	154,100	0	5.00
6.00	50.00	OPERATING ROOM	15,000	10,000	5,000	208,000	36	6.00
7.00	65.00	RESPIRATORY THERAPY	88,332	70,000	18,332	177,200	132	7.00
8.00	69.00	ELECTROCARDIOLOGY	160,000	160,000	0	177,200	0	8.00
9.00	70.00	ELECTROENCEPHALOGRAPHY	720,017	720,017	0	177,200	0	9.00
10.00	74.00	RENAL DIALYSIS	12,600	0	12,600	177,200	72	10.00
11.00	90.00	CLINIC	45,424	45,424	0	177,200	0	11.00
12.00	91.00	EMERGENCY	362,150	297,150	65,000	177,200	468	12.00
13.00	65.01	SLEEP LAB	110,000	110,000	0	0	0	13.00
14.00	60.00	LABORATORY	34,000	25,000	9,000	215,700	60	14.00
15.00	91.01	OP MENTAL HEALTH	4,500	4,500	0	0	0	15.00
16.00	91.02	DIABETES CENTER	5,000	0	5,000	177,200	30	16.00
200.00			4,147,093	4,015,411	131,682		1,134	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	0	0	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	0	0	2.00
3.00	31.00	INTENSIVE CARE UNIT	28,625	1,431	0	0	0	3.00
4.00	40.00	SUBPROVIDER - IPF	0	0	0	0	0	4.00
5.00	41.00	SUBPROVIDER - IRF	0	0	0	0	0	5.00
6.00	50.00	OPERATING ROOM	3,600	180	0	0	0	6.00
7.00	65.00	RESPIRATORY THERAPY	11,245	562	0	0	0	7.00
8.00	69.00	ELECTROCARDIOLOGY	0	0	0	0	0	8.00
9.00	70.00	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	9.00
10.00	74.00	RENAL DIALYSIS	6,134	307	0	0	0	10.00
11.00	90.00	CLINIC	0	0	0	0	0	11.00
12.00	91.00	EMERGENCY	39,870	1,994	0	0	0	12.00
13.00	65.01	SLEEP LAB	0	0	0	0	0	13.00
14.00	60.00	LABORATORY	6,222	311	0	0	0	14.00
15.00	91.01	OP MENTAL HEALTH	0	0	0	0	0	15.00
16.00	91.02	DIABETES CENTER	2,556	128	0	0	0	16.00
200.00			98,252	4,913	0	0	0	200.00

	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col. 14	Adjusted RCE Limit	RCE Disallowance	Adjustment	
	1.00	2.00	15.00	16.00	17.00	18.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	0	0	0	1,188,892	1.00
2.00	30.00	ADULTS & PEDIATRICS	0	0	0	1,257,028	2.00
3.00	31.00	INTENSIVE CARE UNIT	0	28,625	0	0	3.00
4.00	40.00	SUBPROVIDER - IPF	0	0	0	27,400	4.00
5.00	41.00	SUBPROVIDER - IRF	0	0	0	100,000	5.00
6.00	50.00	OPERATING ROOM	0	3,600	1,400	11,400	6.00
7.00	65.00	RESPIRATORY THERAPY	0	11,245	7,087	77,087	7.00
8.00	69.00	ELECTROCARDIOLOGY	0	0	0	160,000	8.00
9.00	70.00	ELECTROENCEPHALOGRAPHY	0	0	0	720,017	9.00
10.00	74.00	RENAL DIALYSIS	0	6,134	6,466	6,466	10.00
11.00	90.00	CLINIC	0	0	0	45,424	11.00
12.00	91.00	EMERGENCY	0	39,870	25,130	322,280	12.00
13.00	65.01	SLEEP LAB	0	0	0	110,000	13.00
14.00	60.00	LABORATORY	0	6,222	2,778	27,778	14.00
15.00	91.01	OP MENTAL HEALTH	0	0	0	4,500	15.00
16.00	91.02	DIABETES CENTER	0	2,556	2,444	2,444	16.00
200.00			0	98,252	45,305	4,060,716	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140213

Period:
From 10/01/2014
To 09/30/2015

Worksheet B
Part I
Date/Time Prepared:
2/19/2016 2:55 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst Allocation)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	30,562,730	30,562,730			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	14,905,061		14,905,061		2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	35,865,650	113,249	4,441	35,983,340	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	44,952,780	7,024,767	6,921,620	4,993,188	63,892,355
7.00 00700	OPERATION OF PLANT	8,538,929	376,039	54,849	924,198	9,894,015
8.00 00800	LAUNDRY & LINEN SERVICE	-39,469	129,348	0	31,148	121,027
9.00 00900	HOUSEKEEPING	3,416,961	320,677	45,219	717,586	4,500,443
10.00 01000	DIETARY	939,359	1,274,461	11,959	142,225	2,368,004
11.00 01100	CAFETERIA	785,578	0	38,373	456,366	1,280,317
13.00 01300	NURSING ADMINISTRATION	1,955,775	161,320	53,492	633,171	2,803,758
14.00 01400	CENTRAL SERVICES & SUPPLY	650,488	1,028,387	213,293	199,763	2,091,931
15.00 01500	PHARMACY	4,732,766	424,503	0	969,905	6,127,174
16.00 01600	MEDICAL RECORDS & LIBRARY	3,070,440	60,074	7,843	645,513	3,783,870
17.00 01700	SOCIAL SERVICE	354,572	0	0	117,078	471,650
23.00 02300	PARAMED PRGM	382,397	47,005	43,724	94,973	568,099
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	26,158,021	6,609,800	496,216	7,831,763	41,095,800
31.00 03100	INTENSIVE CARE UNIT	6,262,423	952,326	225,397	1,767,764	9,207,910
40.00 04000	SUBPROVIDER - I/PF	2,127,306	621,441	20,636	579,789	3,349,172
41.00 04100	SUBPROVIDER - I/RF	3,957,670	1,131,259	23,583	1,109,966	6,222,478
42.00 04200	SUBPROVIDER	0	0	0	0	0
43.00 04300	NURSERY	2,170,521	2,553,578	158,670	454,880	5,337,649
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	0
45.00 04500	NURSING FACILITY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	17,523,632	3,079,439	1,943,237	2,917,623	25,463,931
51.00 05100	RECOVERY ROOM	1,243,018	243,270	33,620	392,125	1,912,033
52.00 05200	DELIVERY ROOM & LABOR ROOM	3,684,041	0	290,025	1,057,372	5,031,438
53.00 05300	ANESTHESIOLOGY	0	0	0	0	0
54.00 05400	RADIOLOGY-DIAGNOSTIC	15,209,379	1,375,034	2,160,049	2,494,849	21,239,311
54.01 05401	ULTRASOUND	1,266,002	168,388	177,813	357,893	1,970,096
57.00 05700	CT SCAN	1,967,164	151,055	419,214	350,245	2,887,678
58.00 05800	MRI	1,049,373	194,751	274,003	186,367	1,704,494
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00 06000	LABORATORY	8,486,977	33,599	47,513	1,193,664	9,761,753
60.01 06001	BLOOD LABORATORY	0	0	0	0	0
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	1,834,094	0	5,432	75,477	1,915,003
65.00 06500	RESPIRATORY THERAPY	1,690,195	110,220	53,752	469,244	2,323,411
65.01 06501	SLEEP LAB	324,261	0	28,171	58,454	410,886
66.00 06600	PHYSICAL THERAPY	1,471,541	13,967	25,476	353,269	1,864,253
67.00 06700	OCCUPATIONAL THERAPY	2,718,552	0	11,956	741,308	3,471,816
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00 06900	ELECTROCARDIOLOGY	1,237,230	81,670	78,007	379,047	1,775,954
70.00 07000	ELECTROENCEPHALOGRAPHY	235,892	58,335	8,834	74,570	377,631
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	13,832,971	0	0	0	13,832,971
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	16,842,908	0	0	0	16,842,908
73.00 07300	DRUGS CHARGED TO PATIENTS	10,965,837	0	574,296	0	11,540,133
74.00 07400	RENAL DIALYSIS	525,604	162,442	32,285	126,092	846,423
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	0
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00 09000	CLINIC	661,915	0	2,724	165,435	830,074
90.01 09001	HOMER GLEN LAB	0	0	0	0	0
90.02 09002	HOMER GLEN FEC	0	0	0	0	0
90.03 09003	WOMEN'S HEALTH	0	0	0	0	0
91.00 09100	EMERGENCY	7,820,013	1,788,823	415,804	2,160,473	12,185,113
91.01 09101	OP MENTAL HEALTH	429,463	172,033	1,774	137,851	741,121
91.02 09102	DIABETES CENTER	251,483	0	462	80,982	332,927
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS						
94.00 09400	HOME PROGRAM DIALYSIS	0	0	0	0	0
99.00 09900	CMHC	0	0	0	0	0
99.10 09910	CORF	0	0	0	0	0
101.00 10100	HOME HEALTH AGENCY	2,731,703	0	1,299	537,255	3,270,257
SPECIAL PURPOSE COST CENTERS						
109.00 10900	PANCREAS ACQUISITION	0	0	0	0	0
110.00 11000	INTESTINAL ACQUISITION	0	0	0	0	0
111.00 11100	ISLET ACQUISITION	0	0	0	0	0

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140213

Period:
From 10/01/2014
To 09/30/2015

Worksheet B
Part I
Date/Time Prepared:
2/19/2016 2:55 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT	Subtotal		
		BLDG & FIXT	MVBLE EQUIP				
	0	1.00	2.00	4.00	4A		
118.00	SUBTOTALS (SUM OF LINES 1-117)	305,753,206	30,461,260	14,905,061	35,978,871	305,647,267	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	13,537	101,470	0	4,469	119,476	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00	Cross Foot Adjustments					0	200.00
201.00	Negative Cost Centers		0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	305,766,743	30,562,730	14,905,061	35,983,340	305,766,743	202.00

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 140213	Period: From 10/01/2014 To 09/30/2015	Worksheet B Part I Date/Time Prepared: 2/19/2016 2:55 am		
Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY
			5.00	7.00	8.00	9.00	10.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	63,892,355				5.00
7.00	00700	OPERATION OF PLANT	2,613,554	12,507,569			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	31,970	70,192	223,189		8.00
9.00	00900	HOUSEKEEPING	1,188,815	174,018	0	5,863,276	9.00
10.00	01000	DIETARY	625,520	691,598	2,167	330,662	4,017,951
11.00	01100	CAFETERIA	338,202	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	740,627	87,542	0	41,855	0
14.00	01400	CENTRAL SERVICES & SUPPLY	552,594	558,063	597	266,818	0
15.00	01500	PHARMACY	1,618,524	230,360	0	110,138	0
16.00	01600	MEDICAL RECORDS & LIBRARY	999,528	32,600	0	15,586	0
17.00	01700	SOCIAL SERVICE	124,589	0	0	0	0
23.00	02300	PARAMED ED PRGM	150,066	25,508	7,892	12,196	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	10,855,682	3,586,867	79,406	1,714,928	2,628,388
31.00	03100	INTENSIVE CARE UNIT	2,432,315	516,788	11,805	247,083	741,891
40.00	04000	SUBPROVIDER - I/PF	884,701	337,230	1,485	161,234	255,412
41.00	04100	SUBPROVIDER - I/RF	1,643,699	613,888	13,388	293,508	392,260
42.00	04200	SUBPROVIDER	0	0	0	0	0
43.00	04300	NURSERY	1,409,967	1,385,722	0	662,532	0
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0
45.00	04500	NURSING FACILITY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	6,726,425	1,671,085	37,040	798,968	0
51.00	05100	RECOVERY ROOM	505,073	132,013	3,286	63,117	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,329,080	0	15,481	0	0
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	5,610,470	746,174	13,849	356,756	0
54.01	05401	ULTRASOUND	520,411	91,377	1,293	43,689	0
57.00	05700	CT SCAN	762,795	81,971	1,293	39,192	0
58.00	05800	MRI	450,251	105,683	2,614	50,529	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	2,578,616	18,233	0	8,717	0
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	505,858	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	613,741	59,812	0	28,597	0
65.01	06501	SLEEP LAB	108,538	0	0	0	0
66.00	06600	PHYSICAL THERAPY	492,452	7,579	0	3,624	0
67.00	06700	OCCUPATIONAL THERAPY	917,098	0	4,979	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	469,127	44,319	246	21,189	0
70.00	07000	ELECTROENCEPHALOGRAPHY	99,753	31,656	0	15,135	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	3,654,048	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	4,449,138	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	3,048,384	0	0	0	0
74.00	07400	RENAL DIALYSIS	223,587	88,150	0	42,146	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00	09000	CLINIC	219,268	0	204	0	0
90.01	09001	HOMER GLEN LAB	0	0	0	0	0
90.02	09002	HOMER GLEN FEC	0	0	0	0	0
90.03	09003	WOMEN'S HEALTH	0	0	0	0	0
91.00	09100	EMERGENCY	3,218,759	970,721	26,164	464,115	0
91.01	09101	OP MENTAL HEALTH	195,771	93,356	0	44,635	0
91.02	09102	DIABETES CENTER	87,944	0	0	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0
99.00	09900	CMHC	0	0	0	0	0
99.10	09910	CORF	0	0	0	0	0
101.00	10100	HOME HEALTH AGENCY	863,855	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0
111.00	11100	ISLET ACQUISITION	0	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	63,860,795	12,452,505	223,189	5,836,949	4,017,951
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	31,560	55,064	0	26,327	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
200.00		Cross Foot Adjustments					200.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 140213			Period: From 10/01/2014 To 09/30/2015		Worksheet B Part I Date/Time Prepared: 2/19/2016 2:55 am	
Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY		
		5.00	7.00	8.00	9.00	10.00		
201.00	Negative Cost Centers	0	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	63,892,355	12,507,569	223,189	5,863,276	4,017,951	0	202.00

COST ALLOCATION - GENERAL SERVICE COSTS			Provider CCN: 140213		Period: From 10/01/2014 To 09/30/2015		Worksheet B Part I Date/Time Prepared: 2/19/2016 2:55 am	
Cost Center Description			CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
			11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA	1,618,519					11.00
13.00	01300	NURSING ADMINISTRATION	34,642	3,708,424				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	23,464	0	3,493,467			14.00
15.00	01500	PHARMACY	39,956	0	29,360	8,155,512		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	51,121	0	2,864	0	4,885,569	16.00
17.00	01700	SOCIAL SERVICE	7,290	0	0	0	0	17.00
23.00	02300	PARAMED PRGM	32,551	0	22,181	31,196	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	457,748	2,366,306	222,940	3,462	1,933,459	30.00
31.00	03100	INTENSIVE CARE UNIT	82,398	425,951	72,428	9,559	595,143	31.00
40.00	04000	SUBPROVIDER - IPF	34,603	0	3,872	0	155,315	40.00
41.00	04100	SUBPROVIDER - IRF	61,266	316,682	14,891	0	151,046	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	23,400	120,938	26,964	0	208,802	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	162,234	0	380,920	0	0	50.00
51.00	05100	RECOVERY ROOM	15,409	0	4,805	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	55,034	284,464	38,503	830	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	146,519	0	108,193	15,635	0	54.00
54.01	05401	ULTRASOUND	17,066	0	13,182	0	0	54.01
57.00	05700	CT SCAN	18,124	0	36,329	0	0	57.00
58.00	05800	MRI	8,030	0	6,850	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	80,652	0	406,790	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	4,321	0	22,708	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	29,225	0	23,576	0	0	65.00
65.01	06501	SLEEP LAB	4,308	0	1,975	0	0	65.01
66.00	06600	PHYSICAL THERAPY	17,576	0	1,648	0	449,747	66.00
67.00	06700	OCCUPATIONAL THERAPY	38,248	0	7,766	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	20,902	0	4,518	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	4,639	0	696	0	104,464	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	1,913,475	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	8,093,993	0	73.00
74.00	07400	RENAL DIALYSIS	4,741	24,504	12,805	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	7,137	0	5,435	0	19,713	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	121,284	0	99,248	0	1,267,880	91.00
91.01	09101	OP MENTAL HEALTH	8,284	0	1,414	0	0	91.01
91.02	09102	DIABETES CENTER	5,480	28,305	7,131	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	141,274	0	837	0	101.00
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	1,617,652	3,708,424	3,493,467	8,155,512	4,885,569	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GI FT, FLOWER, COFFEE SHOP & CANTEEN	867	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140213

Period:
From 10/01/2014
To 09/30/2015

Worksheet B
Part I
Date/Time Prepared:
2/19/2016 2:55 am

Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	1,618,519	3,708,424	3,493,467	8,155,512	4,885,569	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140213

Period:
From 10/01/2014
To 09/30/2015

Worksheet B
Part I
Date/Time Prepared:
2/19/2016 2:55 am

Cost Center Description			SOCIAL SERVICE	PARAMED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	23.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY						10.00
11.00	01100	CAFETERIA						11.00
13.00	01300	NURSING ADMINISTRATION						13.00
14.00	01400	CENTRAL SERVICES & SUPPLY						14.00
15.00	01500	PHARMACY						15.00
16.00	01600	MEDICAL RECORDS & LIBRARY						16.00
17.00	01700	SOCIAL SERVICE	603,529					17.00
23.00	02300	PARAMED PRGM	0	849,689				23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	524,231	0	65,469,217	0	65,469,217	30.00
31.00	03100	INTENSIVE CARE UNIT	32,148	47,864	14,423,283	0	14,423,283	31.00
40.00	04000	SUBPROVIDER - I/PF	0	34,189	5,217,213	0	5,217,213	40.00
41.00	04100	SUBPROVIDER - I/RF	0	0	9,723,106	0	9,723,106	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	9,175,974	0	9,175,974	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	35,240,603	0	35,240,603	50.00
51.00	05100	RECOVERY ROOM	0	0	2,635,736	0	2,635,736	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	29,630	6,784,460	0	6,784,460	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	28,236,907	0	28,236,907	54.00
54.01	05401	ULTRASOUND	0	0	2,657,114	0	2,657,114	54.01
57.00	05700	CT SCAN	0	0	3,827,382	0	3,827,382	57.00
58.00	05800	MRI	0	0	2,328,451	0	2,328,451	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	12,854,761	0	12,854,761	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	2,447,890	0	2,447,890	63.00
65.00	06500	RESPIRATORY THERAPY	0	25,832	3,104,194	0	3,104,194	65.00
65.01	06501	SLEEP LAB	0	0	525,707	0	525,707	65.01
66.00	06600	PHYSICAL THERAPY	0	0	2,836,879	0	2,836,879	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	4,439,907	0	4,439,907	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	18,994	2,355,249	0	2,355,249	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	633,974	0	633,974	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	19,400,494	0	19,400,494	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	21,292,046	0	21,292,046	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	22,682,510	0	22,682,510	73.00
74.00	07400	RENAL DIALYSIS	0	0	1,242,356	0	1,242,356	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	7,501	0	1,089,332	0	1,089,332	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	39,649	693,180	19,086,113	0	19,086,113	91.00
91.01	09101	OP MENTAL HEALTH	0	0	1,084,581	0	1,084,581	91.01
91.02	09102	DIABETES CENTER	0	0	461,787	0	461,787	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	0	0	4,276,223	0	4,276,223	101.00
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	603,529	849,689	305,533,449	0	305,533,449	118.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140213

Period:
From 10/01/2014
To 09/30/2015

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Cost Center Description			SOCIAL SERVICE	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	23.00	24.00	25.00	26.00	
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	233,294	0	233,294	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments	0	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	603,529	849,689	305,766,743	0	305,766,743	202.00

COST ALLOCATION STATISTICS

Provider CCN: 140213

Period:
From 10/01/2014
To 09/30/2015

Worksheet Non-CMS W
Date/Time Prepared:
2/19/2016 2:55 am

Cost Center Description		Statistics Code	Statistics Description	
		1.00	2.00	
GENERAL SERVICE COST CENTERS				
1.00	CAP REL COSTS-BLDG & FIXT	1	SQUARE FEET	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2	DOLLAR VALUE	2.00
4.00	EMPLOYEE BENEFITS DEPARTMENT	S	GROSS SALARIES	4.00
5.00	ADMINISTRATIVE & GENERAL	-1	ACCUM. COST	5.00
7.00	OPERATION OF PLANT	1	SQUARE FEET	7.00
8.00	LAUNDRY & LINEN SERVICE	3	POUNDS OF LAUNDRY	8.00
9.00	HOUSEKEEPING	1	SQUARE FEET	9.00
10.00	DIETARY	4	MEALS SERVED	10.00
11.00	CAFETERIA	5	NUMBER HOUSED	11.00
13.00	NURSING ADMINISTRATION	6	DIRECT NRSING	13.00
14.00	CENTRAL SERVICES & SUPPLY	7	COSTED REQUIS.	14.00
15.00	PHARMACY	8	COSTED REQUIS.	15.00
16.00	MEDICAL RECORDS & LIBRARY	9	TIME SPENT	16.00
17.00	SOCIAL SERVICE	10	TIME SPENT	17.00
23.00	PARAMED ED PRGM	11	ASSIGNED TIME	23.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 140213		Period: From 10/01/2014 To 09/30/2015		Worksheet B Part II Date/Time Prepared: 2/19/2016 2:55 am	
Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT			
		BLDG & FIXT	MVBLE EQUIP					
	0	1.00	2.00	2A	4.00			
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00	
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00	
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	0	113,249	4,441	117,690	4.00	
5.00	00500	ADMINISTRATIVE & GENERAL	0	7,024,767	6,921,620	13,946,387	5.00	
7.00	00700	OPERATION OF PLANT	0	376,039	54,849	430,888	7.00	
8.00	00800	LAUNDRY & LINEN SERVICE	0	129,348	0	129,348	8.00	
9.00	00900	HOUSEKEEPING	0	320,677	45,219	365,896	9.00	
10.00	01000	DIETARY	0	1,274,461	11,959	1,286,420	10.00	
11.00	01100	CAFETERIA	0	0	38,373	38,373	11.00	
13.00	01300	NURSING ADMINISTRATION	0	161,320	53,492	214,812	13.00	
14.00	01400	CENTRAL SERVICES & SUPPLY	0	1,028,387	213,293	1,241,680	14.00	
15.00	01500	PHARMACY	0	424,503	0	424,503	15.00	
16.00	01600	MEDICAL RECORDS & LIBRARY	0	60,074	7,843	67,917	16.00	
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00	
23.00	02300	PARAMED PRGM	0	47,005	43,724	90,729	23.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	6,609,800	496,216	7,106,016	30.00	
31.00	03100	INTENSIVE CARE UNIT	0	952,326	225,397	1,177,723	31.00	
40.00	04000	SUBPROVIDER - IPF	0	621,441	20,636	642,077	40.00	
41.00	04100	SUBPROVIDER - IRF	0	1,131,259	23,583	1,154,842	41.00	
42.00	04200	SUBPROVIDER	0	0	0	0	42.00	
43.00	04300	NURSERY	0	2,553,578	158,670	2,712,248	43.00	
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	44.00	
45.00	04500	NURSING FACILITY	0	0	0	0	45.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	3,079,439	1,943,237	5,022,676	50.00	
51.00	05100	RECOVERY ROOM	0	243,270	33,620	276,890	51.00	
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	290,025	290,025	52.00	
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00	
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	1,375,034	2,160,049	3,535,083	54.00	
54.01	05401	ULTRASOUND	0	168,388	177,813	346,201	54.01	
57.00	05700	CT SCAN	0	151,055	419,214	570,269	57.00	
58.00	05800	MRI	0	194,751	274,003	468,754	58.00	
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00	
60.00	06000	LABORATORY	0	33,599	47,513	81,112	60.00	
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01	
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	5,432	5,432	63.00	
65.00	06500	RESPIRATORY THERAPY	0	110,220	53,752	163,972	65.00	
65.01	06501	SLEEP LAB	0	0	28,171	28,171	65.01	
66.00	06600	PHYSICAL THERAPY	0	13,967	25,476	39,443	66.00	
67.00	06700	OCCUPATIONAL THERAPY	0	0	11,956	11,956	67.00	
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00	
69.00	06900	ELECTROCARDIOLOGY	0	81,670	78,007	159,677	69.00	
70.00	07000	ELECTROENCEPHALOGRAPHY	0	58,335	8,834	67,169	70.00	
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00	
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00	
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	574,296	574,296	73.00	
74.00	07400	RENAL DIALYSIS	0	162,442	32,285	194,727	74.00	
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00	
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00	
90.00	09000	CLINIC	0	0	2,724	2,724	90.00	
90.01	09001	HOMER GLEN LAB	0	0	0	0	90.01	
90.02	09002	HOMER GLEN FEC	0	0	0	0	90.02	
90.03	09003	WOMEN'S HEALTH	0	0	0	0	90.03	
91.00	09100	EMERGENCY	0	1,788,823	415,804	2,204,627	91.00	
91.01	09101	OP MENTAL HEALTH	0	172,033	1,774	173,807	91.01	
91.02	09102	DIABETES CENTER	0	0	462	462	91.02	
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00	
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	94.00	
99.00	09900	CMHC	0	0	0	0	99.00	
99.10	09910	CORF	0	0	0	0	99.10	
101.00	10100	HOME HEALTH AGENCY	0	0	1,299	1,299	101.00	
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	109.00	
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	110.00	
111.00	11100	ISLET ACQUISITION	0	0	0	0	111.00	
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	30,461,260	14,905,061	45,366,321	118.00	

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140213

Period:
From 10/01/2014
To 09/30/2015

Worksheet B
Part II
Date/Time Prepared:
2/19/2016 2:55 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
		BLDG & FIXT	MVBLE EQUIP			
		1.00	2.00			
NONREIMBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	101,470	0	101,470	15	190.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00 Cross Foot Adjustments				0		200.00
201.00 Negative Cost Centers		0	0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	0	30,562,730	14,905,061	45,467,791	117,690	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 140213	Period: From 10/01/2014 To 09/30/2015	Worksheet B Part II Date/Time Prepared: 2/19/2016 2:55 am		
Cost Center Description			ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY
			5.00	7.00	8.00	9.00	10.00
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	13,962,719				5.00
7.00	00700	OPERATION OF PLANT	571,152	1,005,063			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	6,987	5,640	120,727		8.00
9.00	00900	HOUSEKEEPING	259,797	13,983	0	642,023	9.00
10.00	01000	DIETARY	136,698	55,574	1,172	36,207	1,516,536
11.00	01100	CAFETERIA	73,909	0	0	0	0
13.00	01300	NURSING ADMINISTRATION	161,853	7,035	0	4,583	0
14.00	01400	CENTRAL SERVICES & SUPPLY	120,761	44,844	323	29,216	0
15.00	01500	PHARMACY	353,703	18,511	0	12,060	0
16.00	01600	MEDICAL RECORDS & LIBRARY	218,431	2,620	0	1,707	0
17.00	01700	SOCIAL SERVICE	27,227	0	0	0	0
23.00	02300	PARAMED ED PRGM	32,795	2,050	4,269	1,335	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,372,371	288,227	42,954	187,785	992,059
31.00	03100	INTENSIVE CARE UNIT	531,545	41,527	6,386	27,055	280,019
40.00	04000	SUBPROVIDER - I/PF	193,338	27,099	803	17,655	96,403
41.00	04100	SUBPROVIDER - I/RF	359,205	49,330	7,242	32,139	148,055
42.00	04200	SUBPROVIDER	0	0	0	0	0
43.00	04300	NURSERY	308,126	111,352	0	72,547	0
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0
45.00	04500	NURSING FACILITY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	1,469,956	134,282	20,036	87,486	0
51.00	05100	RECOVERY ROOM	110,376	10,608	1,777	6,911	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	290,450	0	8,374	0	0
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,226,082	59,960	7,491	39,064	0
54.01	05401	ULTRASOUND	113,728	7,343	699	4,784	0
57.00	05700	CT SCAN	166,697	6,587	699	4,291	0
58.00	05800	MRI	98,395	8,492	1,414	5,533	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	563,517	1,465	0	955	0
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	110,547	0	0	0	0
65.00	06500	RESPIRATORY THERAPY	134,124	4,806	0	3,131	0
65.01	06501	SLEEP LAB	23,719	0	0	0	0
66.00	06600	PHYSICAL THERAPY	107,618	609	0	397	0
67.00	06700	OCCUPATIONAL THERAPY	200,418	0	2,693	0	0
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	102,520	3,561	133	2,320	0
70.00	07000	ELECTROENCEPHALOGRAPHY	21,800	2,544	0	1,657	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	798,536	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	972,291	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	666,177	0	0	0	0
74.00	07400	RENAL DIALYSIS	48,861	7,083	0	4,615	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00	09000	CLINIC	47,918	0	110	0	0
90.01	09001	HOMER GLEN LAB	0	0	0	0	0
90.02	09002	HOMER GLEN FEC	0	0	0	0	0
90.03	09003	WOMEN'S HEALTH	0	0	0	0	0
91.00	09100	EMERGENCY	703,410	78,004	14,152	50,820	0
91.01	09101	OP MENTAL HEALTH	42,783	7,502	0	4,887	0
91.02	09102	DIABETES CENTER	19,219	0	0	0	0
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0
99.00	09900	CMHC	0	0	0	0	0
99.10	09910	CORF	0	0	0	0	0
101.00	10100	HOME HEALTH AGENCY	188,782	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0
111.00	11100	ISLET ACQUISITION	0	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	13,955,822	1,000,638	120,727	639,140	1,516,536
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	6,897	4,425	0	2,883	0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0
200.00		Cross Foot Adjustments					200.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140213			Period: From 10/01/2014 To 09/30/2015		Worksheet B Part II Date/Time Prepared: 2/19/2016 2:55 am	
Cost Center Description		ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY		
		5.00	7.00	8.00	9.00	10.00		
201.00	Negative Cost Centers	0	0	21,350	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	13,962,719	1,005,063	142,077	642,023	1,516,536	0	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140213		Period: From 10/01/2014 To 09/30/2015		Worksheet B Part II Date/Time Prepared: 2/19/2016 2:55 am	
Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	113,775					11.00
13.00	01300	2,435	392,789				13.00
14.00	01400	1,649	0	1,439,126			14.00
15.00	01500	2,809	0	12,095	826,853		15.00
16.00	01600	3,594	0	1,180	0	297,560	16.00
17.00	01700	512	0	0	0	0	17.00
23.00	02300	2,288	0	9,138	3,163	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	32,180	250,635	91,840	351	117,759	30.00
31.00	03100	5,792	45,116	29,837	969	36,248	31.00
40.00	04000	2,432	0	1,595	0	9,460	40.00
41.00	04100	4,307	33,542	6,134	0	9,200	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	1,645	12,810	11,108	0	12,717	43.00
44.00	04400	0	0	0	0	0	44.00
45.00	04500	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	11,404	0	156,920	0	0	50.00
51.00	05100	1,083	0	1,980	0	0	51.00
52.00	05200	3,869	30,130	15,861	84	0	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	10,300	0	44,570	1,585	0	54.00
54.01	05401	1,200	0	5,430	0	0	54.01
57.00	05700	1,274	0	14,966	0	0	57.00
58.00	05800	564	0	2,822	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	5,669	0	167,577	0	0	60.00
60.01	06001	0	0	0	0	0	60.01
63.00	06300	304	0	9,355	0	0	63.00
65.00	06500	2,054	0	9,712	0	0	65.00
65.01	06501	303	0	814	0	0	65.01
66.00	06600	1,235	0	679	0	27,392	66.00
67.00	06700	2,689	0	3,199	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	1,469	0	1,861	0	0	69.00
70.00	07000	326	0	287	0	6,362	70.00
71.00	07100	0	0	788,246	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	0	820,616	0	73.00
74.00	07400	333	2,595	5,275	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	502	0	2,239	0	1,201	90.00
90.01	09001	0	0	0	0	0	90.01
90.02	09002	0	0	0	0	0	90.02
90.03	09003	0	0	0	0	0	90.03
91.00	09100	8,526	0	40,885	0	77,221	91.00
91.01	09101	582	0	583	0	0	91.01
91.02	09102	385	2,998	2,938	0	0	91.02
92.00	09200	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	0	0	0	0	0	94.00
99.00	09900	0	0	0	0	0	99.00
99.10	09910	0	0	0	0	0	99.10
101.00	10100	0	14,963	0	85	0	101.00
SPECIAL PURPOSE COST CENTERS							
109.00	10900	0	0	0	0	0	109.00
110.00	11000	0	0	0	0	0	110.00
111.00	11100	0	0	0	0	0	111.00
118.00		113,714	392,789	1,439,126	826,853	297,560	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	61	0	0	0	0	190.00
192.00	19200	0	0	0	0	0	192.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140213			Period: From 10/01/2014 To 09/30/2015		Worksheet B Part II Date/Time Prepared: 2/19/2016 2:55 am	
Cost Center Description		CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY		
		11.00	13.00	14.00	15.00	16.00		
200.00	Cross Foot Adjustments							200.00
201.00	Negative Cost Centers	0	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	113,775	392,789	1,439,126	826,853	297,560		202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140213

Period:
From 10/01/2014
To 09/30/2015

Worksheet B
Part II
Date/Time Prepared:
2/19/2016 2:55 am

Cost Center Description		SOCIAL SERVICE	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
		17.00	23.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300						13.00
14.00	01400						14.00
15.00	01500						15.00
16.00	01600						16.00
17.00	01700	28,122					17.00
23.00	02300		146,078				23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	24,426		11,532,215	0	11,532,215	30.00
31.00	03100	1,498		2,189,497	0	2,189,497	31.00
40.00	04000	0		992,758	0	992,758	40.00
41.00	04100	0		1,807,626	0	1,807,626	41.00
42.00	04200	0		0	0	0	42.00
43.00	04300	0		3,244,041	0	3,244,041	43.00
44.00	04400	0		0	0	0	44.00
45.00	04500	0		0	0	0	45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0		6,912,303	0	6,912,303	50.00
51.00	05100	0		410,908	0	410,908	51.00
52.00	05200	0		642,251	0	642,251	52.00
53.00	05300	0		0	0	0	53.00
54.00	05400	0		4,932,295	0	4,932,295	54.00
54.01	05401	0		480,556	0	480,556	54.01
57.00	05700	0		765,929	0	765,929	57.00
58.00	05800	0		586,584	0	586,584	58.00
59.00	05900	0		0	0	0	59.00
60.00	06000	0		824,199	0	824,199	60.00
60.01	06001	0		0	0	0	60.01
63.00	06300	0		125,885	0	125,885	63.00
65.00	06500	0		319,334	0	319,334	65.00
65.01	06501	0		53,198	0	53,198	65.01
66.00	06600	0		178,528	0	178,528	66.00
67.00	06700	0		223,380	0	223,380	67.00
68.00	06800	0		0	0	0	68.00
69.00	06900	0		272,781	0	272,781	69.00
70.00	07000	0		100,389	0	100,389	70.00
71.00	07100	0		1,586,782	0	1,586,782	71.00
72.00	07200	0		972,291	0	972,291	72.00
73.00	07300	0		2,061,089	0	2,061,089	73.00
74.00	07400	0		263,901	0	263,901	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0		0	0	0	88.00
89.00	08900	0		0	0	0	89.00
90.00	09000	350		55,585	0	55,585	90.00
90.01	09001	0		0	0	0	90.01
90.02	09002	0		0	0	0	90.02
90.03	09003	0		0	0	0	90.03
91.00	09100	1,848		3,186,559	0	3,186,559	91.00
91.01	09101	0		230,595	0	230,595	91.01
91.02	09102	0		26,267	0	26,267	91.02
92.00	09200	0		0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	0		0	0	0	94.00
99.00	09900	0		0	0	0	99.00
99.10	09910	0		0	0	0	99.10
101.00	10100	0		206,886	0	206,886	101.00
SPECIAL PURPOSE COST CENTERS							
109.00	10900	0		0	0	0	109.00
110.00	11000	0		0	0	0	110.00
111.00	11100	0		0	0	0	111.00
118.00		28,122	0	45,184,612	0	45,184,612	118.00
SUBTOTALS (SUM OF LINES 1-117)							

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 140213		Period: From 10/01/2014 To 09/30/2015		Worksheet B Part II Date/Time Prepared: 2/19/2016 2:55 am	
Cost Center Description			SOCIAL SERVICE	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			17.00	23.00	24.00	25.00	26.00	
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		115,751	0	115,751	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		0	0	0	192.00
200.00		Cross Foot Adjustments		146,078	146,078	0	146,078	200.00
201.00		Negative Cost Centers	0	0	21,350	0	21,350	201.00
202.00		TOTAL (sum lines 118-201)	28,122	146,078	45,467,791	0	45,467,791	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140213

Period:
From 10/01/2014
To 09/30/2015

Worksheet B-1
Date/Time Prepared:
2/19/2016 2:55 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	544,870				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		13,686,362			2.00
4.00 00400	EMPLOYEE BENEFITS DEPARTMENT	2,019	4,078	108,975,583		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	125,237	6,355,683	15,121,892	-63,892,355	5.00
7.00 00700	OPERATION OF PLANT	6,704	50,364	2,798,938	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	2,306	0	94,333	0	8.00
9.00 00900	HOUSEKEEPING	5,717	41,522	2,173,211	0	9.00
10.00 01000	DIETARY	22,721	10,981	430,729	0	10.00
11.00 01100	CAFETERIA	0	35,235	1,382,107	0	11.00
13.00 01300	NURSING ADMINISTRATION	2,876	49,118	1,917,561	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	18,334	195,853	604,984	0	14.00
15.00 01500	PHARMACY	7,568	0	2,937,362	0	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	1,071	7,202	1,954,940	0	16.00
17.00 01700	SOCIAL SERVICE	0	0	354,572	0	17.00
23.00 02300	PARAMED PRGM	838	40,149	287,627	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	117,839	455,643	23,718,405	0	30.00
31.00 03100	INTENSIVE CARE UNIT	16,978	206,968	5,353,682	0	31.00
40.00 04000	SUBPROVIDER - I PF	11,079	18,949	1,755,893	0	40.00
41.00 04100	SUBPROVIDER - I RF	20,168	21,655	3,361,538	0	41.00
42.00 04200	SUBPROVIDER	0	0	0	0	42.00
43.00 04300	NURSERY	45,525	145,696	1,377,606	0	43.00
44.00 04400	SKILLED NURSING FACILITY	0	0	0	0	44.00
45.00 04500	NURSING FACILITY	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	54,900	1,784,350	8,836,034	0	50.00
51.00 05100	RECOVERY ROOM	4,337	30,871	1,187,553	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	266,311	3,202,255	0	52.00
53.00 05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	24,514	1,983,434	7,555,662	0	54.00
54.01 05401	ULTRASOUND	3,002	163,274	1,083,881	0	54.01
57.00 05700	CT SCAN	2,693	384,937	1,060,718	0	57.00
58.00 05800	MRI	3,472	251,599	564,412	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00 06000	LABORATORY	599	43,628	3,615,017	0	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	60.01
63.00 06300	BLOOD STORING, PROCESSING & TRANS.	0	4,988	228,581	0	63.00
65.00 06500	RESPIRATORY THERAPY	1,965	49,357	1,421,108	0	65.00
65.01 06501	SLEEP LAB	0	25,868	177,028	0	65.01
66.00 06600	PHYSICAL THERAPY	249	23,393	1,069,878	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	10,978	2,245,055	0	67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00 06900	ELECTROCARDIOLOGY	1,456	71,629	1,147,945	0	69.00
70.00 07000	ELECTROENCEPHALOGRAPHY	1,040	8,112	225,835	0	70.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	527,339	0	0	73.00
74.00 07400	RENAL DIALYSIS	2,896	29,645	381,871	0	74.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00 09000	CLINIC	0	2,501	501,020	0	90.00
90.01 09001	HOMER GLEN LAB	0	0	0	0	90.01
90.02 09002	HOMER GLEN FEC	0	0	0	0	90.02
90.03 09003	WOMEN'S HEALTH	0	0	0	0	90.03
91.00 09100	EMERGENCY	31,891	381,806	6,543,003	0	91.00
91.01 09101	OP MENTAL HEALTH	3,067	1,629	417,481	0	91.01
91.02 09102	DIABETES CENTER	0	424	245,254	0	91.02
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400	HOME PROGRAM DIALYSIS	0	0	0	0	94.00
99.00 09900	CMHC	0	0	0	0	99.00
99.10 09910	CORF	0	0	0	0	99.10
101.00 10100	HOME HEALTH AGENCY	0	1,193	1,627,079	0	101.00
SPECIAL PURPOSE COST CENTERS						
109.00 10900	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00 11000	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00 11100	ISLET ACQUISITION	0	0	0	0	111.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140213

Period:
From 10/01/2014
To 09/30/2015

Worksheet B-1

Date/Time Prepared:
2/19/2016 2:55 am

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)		
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)						
	1.00	2.00	4.00					
118.00	SUBTOTALS (SUM OF LINES 1-117)				5A	5.00	118.00	
	543,061			13,686,362	-63,892,355	241,754,912		
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,809	0	13,533	0	119,476	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192.00
200.00		Cross Foot Adjustments						200.00
201.00		Negative Cost Centers						201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	30,562,730	14,905,061	35,983,340		63,892,355	202.00
203.00		Unit cost multiplier (Wkst. B, Part I)	56.091783	1.089045	0.330196		0.264155	203.00
204.00		Cost to be allocated (per Wkst. B, Part II)			117,690		13,962,719	204.00
205.00		Unit cost multiplier (Wkst. B, Part II)			0.001080		0.057727	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140213

Period:
From 10/01/2014
To 09/30/2015

Worksheet B-1

Date/Time Prepared:
2/19/2016 2:55 am

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (NUMBER HOUSED)	
		7.00	8.00	9.00	10.00	11.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
7.00	00700	OPERATION OF PLANT	410,910				7.00
8.00	00800	LAUNDRY & LINEN SERVICE	2,306	2,649,515			8.00
9.00	00900	HOUSEKEEPING	5,717	0	402,887		9.00
10.00	01000	DIETARY	22,721	25,720	22,721	234,034	10.00
11.00	01100	CAFETERIA	0	0	0	126,990	11.00
13.00	01300	NURSING ADMINISTRATION	2,876	0	2,876	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	18,334	7,082	18,334	0	14.00
15.00	01500	PHARMACY	7,568	0	7,568	0	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,071	0	1,071	0	16.00
17.00	01700	SOCIAL SERVICE	0	0	0	0	17.00
23.00	02300	PARAMED ED PRGM	838	93,689	838	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	117,839	942,665	117,839	153,096	35,915
31.00	03100	INTENSIVE CARE UNIT	16,978	140,143	16,978	43,213	6,465
40.00	04000	SUBPROVIDER - I/PF	11,079	17,627	11,079	14,877	2,715
41.00	04100	SUBPROVIDER - I/RF	20,168	158,930	20,168	22,848	4,807
42.00	04200	SUBPROVIDER	0	0	0	0	0
43.00	04300	NURSERY	45,525	0	45,525	0	1,836
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0
45.00	04500	NURSING FACILITY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	54,900	439,704	54,900	0	12,729
51.00	05100	RECOVERY ROOM	4,337	39,008	4,337	0	1,209
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	183,774	0	0	4,318
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	24,514	164,408	24,514	0	11,496
54.01	05401	ULTRASOUND	3,002	15,349	3,002	0	1,339
57.00	05700	CT SCAN	2,693	15,349	2,693	0	1,422
58.00	05800	MRI	3,472	31,033	3,472	0	630
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	599	0	599	0	6,328
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	339
65.00	06500	RESPIRATORY THERAPY	1,965	0	1,965	0	2,293
65.01	06501	SLEEP LAB	0	0	0	0	338
66.00	06600	PHYSICAL THERAPY	249	0	249	0	1,379
67.00	06700	OCCUPATIONAL THERAPY	0	59,104	0	0	3,001
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0
69.00	06900	ELECTROCARDIOLOGY	1,456	2,921	1,456	0	1,640
70.00	07000	ELECTROENCEPHALOGRAPHY	1,040	0	1,040	0	364
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
74.00	07400	RENAL DIALYSIS	2,896	0	2,896	0	372
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00	09000	CLINIC	0	2,417	0	0	560
90.01	09001	HOMER GLEN LAB	0	0	0	0	0
90.02	09002	HOMER GLEN FEC	0	0	0	0	0
90.03	09003	WOMEN'S HEALTH	0	0	0	0	0
91.00	09100	EMERGENCY	31,891	310,592	31,891	0	9,516
91.01	09101	OP MENTAL HEALTH	3,067	0	3,067	0	650
91.02	09102	DIABETES CENTER	0	0	0	0	430
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0
99.00	09900	CMHC	0	0	0	0	0
99.10	09910	CORF	0	0	0	0	0
101.00	10100	HOME HEALTH AGENCY	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0
111.00	11100	ISLET ACQUISITION	0	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	409,101	2,649,515	401,078	234,034	126,922
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	1,809	0	1,809	0	68

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140213

Period:
From 10/01/2014
To 09/30/2015

Worksheet B-1

Date/Time Prepared:
2/19/2016 2:55 am

Cost Center Description		OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (NUMBER HOUSED)	
		7.00	8.00	9.00	10.00	11.00	
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	12,507,569	223,189	5,863,276	4,017,951	1,618,519
203.00		Unit cost multiplier (Wkst. B, Part I)	30.438707	0.084238	14.553153	17.168236	12.745248
204.00		Cost to be allocated (per Wkst. B, Part II)	1,005,063	142,077	642,023	1,516,536	113,775
205.00		Unit cost multiplier (Wkst. B, Part II)	2.445944	0.045566	1.593556	6.479982	0.895937

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140213

Period:
From 10/01/2014
To 09/30/2015

Worksheet B-1
Date/Time Prepared:
2/19/2016 2:55 am

Cost Center Description		NURSING ADMINISTRATION (DIRECT NRS ING)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	
		13.00	14.00	15.00	16.00	17.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100						11.00
13.00	01300	1,170,744					13.00
14.00	01400	0	25,591,399				14.00
15.00	01500	0	215,074	11,049,183			15.00
16.00	01600	0	20,978	0	38,911		16.00
17.00	01700	0	0	0	0	2,816	17.00
23.00	02300	0	162,490	42,265	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	747,039	1,633,153	4,690	15,399	2,446	30.00
31.00	03100	134,472	530,574	12,951	4,740	150	31.00
40.00	04000	0	28,364	0	1,237	0	40.00
41.00	04100	99,976	109,086	0	1,203	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	38,180	197,523	0	1,663	0	43.00
44.00	04400	0	0	0	0	0	44.00
45.00	04500	0	0	0	0	0	45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	2,790,436	0	0	0	50.00
51.00	05100	0	35,202	0	0	0	51.00
52.00	05200	89,805	282,057	1,124	0	0	52.00
53.00	05300	0	0	0	0	0	53.00
54.00	05400	0	792,571	21,183	0	0	54.00
54.01	05401	0	96,565	0	0	0	54.01
57.00	05700	0	266,129	0	0	0	57.00
58.00	05800	0	50,183	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	0	2,979,950	0	0	0	60.00
60.01	06001	0	0	0	0	0	60.01
63.00	06300	0	166,348	0	0	0	63.00
65.00	06500	0	172,708	0	0	0	65.00
65.01	06501	0	14,467	0	0	0	65.01
66.00	06600	0	12,069	0	3,582	0	66.00
67.00	06700	0	56,887	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	0	33,096	0	0	0	69.00
70.00	07000	0	5,101	0	832	0	70.00
71.00	07100	0	14,017,123	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	0	10,965,836	0	0	73.00
74.00	07400	7,736	93,807	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	0	39,814	0	157	35	90.00
90.01	09001	0	0	0	0	0	90.01
90.02	09002	0	0	0	0	0	90.02
90.03	09003	0	0	0	0	0	90.03
91.00	09100	0	727,044	0	10,098	185	91.00
91.01	09101	0	10,360	0	0	0	91.01
91.02	09102	8,936	52,240	0	0	0	91.02
92.00	09200	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	0	0	0	0	0	94.00
99.00	09900	0	0	0	0	0	99.00
99.10	09910	0	0	0	0	0	99.10
101.00	10100	44,600	0	1,134	0	0	101.00
SPECIAL PURPOSE COST CENTERS							
109.00	10900	0	0	0	0	0	109.00
110.00	11000	0	0	0	0	0	110.00
111.00	11100	0	0	0	0	0	111.00
118.00		1,170,744	25,591,399	11,049,183	38,911	2,816	118.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140213

Period:
From 10/01/2014
To 09/30/2015

Worksheet B-1

Date/Time Prepared:
2/19/2016 2:55 am

Cost Center Description		NURSING ADMINISTRATION (DIRECT NRS ING)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	
		13.00	14.00	15.00	16.00	17.00	
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0	0	0	0	192.00
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,708,424	3,493,467	8,155,512	4,885,569	603,529
203.00		Unit cost multiplier (Wkst. B, Part I)	3.167579	0.136509	0.738110	125.557529	214.321378
204.00		Cost to be allocated (per Wkst. B, Part II)	392,789	1,439,126	826,853	297,560	28,122
205.00		Unit cost multiplier (Wkst. B, Part II)	0.335504	0.056235	0.074834	7.647195	9.986506

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140213

Period:
From 10/01/2014
To 09/30/2015

Worksheet B-1
Date/Time Prepared:
2/19/2016 2:55 am

Cost Center Description		PARAMED PRGM (ASSIGNED TIME)	
		23.00	
GENERAL SERVICE COST CENTERS			
1.00	00100	CAP REL COSTS-BLDG & FIXT	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	2.00
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	5.00
7.00	00700	OPERATION OF PLANT	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	8.00
9.00	00900	HOUSEKEEPING	9.00
10.00	01000	DIETARY	10.00
11.00	01100	CAFETERIA	11.00
13.00	01300	NURSING ADMINISTRATION	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	14.00
15.00	01500	PHARMACY	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	16.00
17.00	01700	SOCIAL SERVICE	17.00
23.00	02300	PARAMED PRGM	23.00
		8,947	
INPATIENT ROUTINE SERVICE COST CENTERS			
30.00	03000	ADULTS & PEDIATRICS	30.00
31.00	03100	INTENSIVE CARE UNIT	31.00
40.00	04000	SUBPROVIDER - I PF	40.00
41.00	04100	SUBPROVIDER - I RF	41.00
42.00	04200	SUBPROVIDER	42.00
43.00	04300	NURSERY	43.00
44.00	04400	SKILLED NURSING FACILITY	44.00
45.00	04500	NURSING FACILITY	45.00
ANCILLARY SERVICE COST CENTERS			
50.00	05000	OPERATING ROOM	50.00
51.00	05100	RECOVERY ROOM	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	52.00
53.00	05300	ANESTHESIOLOGY	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	54.00
54.01	05401	ULTRASOUND	54.01
57.00	05700	CT SCAN	57.00
58.00	05800	MRI	58.00
59.00	05900	CARDIAC CATHETERIZATION	59.00
60.00	06000	LABORATORY	60.00
60.01	06001	BLOOD LABORATORY	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	63.00
65.00	06500	RESPIRATORY THERAPY	65.00
65.01	06501	SLEEP LAB	65.01
66.00	06600	PHYSICAL THERAPY	66.00
67.00	06700	OCCUPATIONAL THERAPY	67.00
68.00	06800	SPEECH PATHOLOGY	68.00
69.00	06900	ELECTROCARDIOLOGY	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	73.00
74.00	07400	RENAL DIALYSIS	74.00
OUTPATIENT SERVICE COST CENTERS			
88.00	08800	RURAL HEALTH CLINIC	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	89.00
90.00	09000	CLINIC	90.00
90.01	09001	HOMER GLEN LAB	90.01
90.02	09002	HOMER GLEN FEC	90.02
90.03	09003	WOMEN'S HEALTH	90.03
91.00	09100	EMERGENCY	91.00
91.01	09101	OP MENTAL HEALTH	91.01
91.02	09102	DIABETES CENTER	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	92.00
OTHER REIMBURSABLE COST CENTERS			
94.00	09400	HOME PROGRAM DIALYSIS	94.00
99.00	09900	CMHC	99.00
99.10	09910	CORF	99.10
101.00	10100	HOME HEALTH AGENCY	101.00
SPECIAL PURPOSE COST CENTERS			
109.00	10900	PANCREAS ACQUISITION	109.00
110.00	11000	INTESTINAL ACQUISITION	110.00
111.00	11100	ISLET ACQUISITION	111.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	118.00
		8,947	
NONREIMBURSABLE COST CENTERS			
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140213

Period:
From 10/01/2014
To 09/30/2015

Worksheet B-1
Date/Time Prepared:
2/19/2016 2:55 am

Cost Center Description		PARAMED ED PRGM (ASSIGNED TIME)	
		23.00	
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	192.00
200.00	Cross Foot Adjustments		200.00
201.00	Negative Cost Centers		201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	849,689	202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	94.969152	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	146,078	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	16.327037	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140213

Period:
From 10/01/2014
To 09/30/2015

Worksheet C
Part I
Date/Time Prepared:
2/19/2016 2:55 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	65,469,217	65,469,217	0	65,469,217	30.00	
31.00	03100 INTENSIVE CARE UNIT	14,423,283	14,423,283	0	14,423,283	31.00	
40.00	04000 SUBPROVIDER - I/PF	5,217,213	5,217,213	0	5,217,213	40.00	
41.00	04100 SUBPROVIDER - I/RF	9,723,106	9,723,106	0	9,723,106	41.00	
42.00	04200 SUBPROVIDER	0	0	0	0	42.00	
43.00	04300 NURSERY	9,175,974	9,175,974	0	9,175,974	43.00	
44.00	04400 SKILLED NURSING FACILITY	0	0	0	0	44.00	
45.00	04500 NURSING FACILITY	0	0	0	0	45.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	35,240,603	35,240,603	1,400	35,242,003	50.00	
51.00	05100 RECOVERY ROOM	2,635,736	2,635,736	0	2,635,736	51.00	
52.00	05200 DELIVERY ROOM & LABOR ROOM	6,784,460	6,784,460	0	6,784,460	52.00	
53.00	05300 ANESTHESIOLOGY	0	0	0	0	53.00	
54.00	05400 RADIOLOGY-DIAGNOSTIC	28,236,907	28,236,907	0	28,236,907	54.00	
54.01	05401 ULTRASOUND	2,657,114	2,657,114	0	2,657,114	54.01	
57.00	05700 CT SCAN	3,827,382	3,827,382	0	3,827,382	57.00	
58.00	05800 MRI	2,328,451	2,328,451	0	2,328,451	58.00	
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	59.00	
60.00	06000 LABORATORY	12,854,761	12,854,761	2,778	12,857,539	60.00	
60.01	06001 BLOOD LABORATORY	0	0	0	0	60.01	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	2,447,890	2,447,890	0	2,447,890	63.00	
65.00	06500 RESPIRATORY THERAPY	3,104,194	3,104,194	7,087	3,111,281	65.00	
65.01	06501 SLEEP LAB	525,707	525,707	0	525,707	65.01	
66.00	06600 PHYSICAL THERAPY	2,836,879	2,836,879	0	2,836,879	66.00	
67.00	06700 OCCUPATIONAL THERAPY	4,439,907	4,439,907	0	4,439,907	67.00	
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	68.00	
69.00	06900 ELECTROCARDIOLOGY	2,355,249	2,355,249	0	2,355,249	69.00	
70.00	07000 ELECTROENCEPHALOGRAPHY	633,974	633,974	0	633,974	70.00	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	19,400,494	19,400,494	0	19,400,494	71.00	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	21,292,046	21,292,046	0	21,292,046	72.00	
73.00	07300 DRUGS CHARGED TO PATIENTS	22,682,510	22,682,510	0	22,682,510	73.00	
74.00	07400 RENAL DIALYSIS	1,242,356	1,242,356	6,466	1,248,822	74.00	
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	88.00	
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00	
90.00	09000 CLINIC	1,089,332	1,089,332	0	1,089,332	90.00	
90.01	09001 HOMER GLEN LAB	0	0	0	0	90.01	
90.02	09002 HOMER GLEN FEC	0	0	0	0	90.02	
90.03	09003 WOMEN'S HEALTH	0	0	0	0	90.03	
91.00	09100 EMERGENCY	19,086,113	19,086,113	25,130	19,111,243	91.00	
91.01	09101 OP MENTAL HEALTH	1,084,581	1,084,581	0	1,084,581	91.01	
91.02	09102 DIABETES CENTER	461,787	461,787	2,444	464,231	91.02	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	7,917,751	7,917,751	0	7,917,751	92.00	
OTHER REIMBURSABLE COST CENTERS							
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0	0	94.00	
99.00	09900 CMHC	0	0	0	0	99.00	
99.10	09910 CORF	0	0	0	0	99.10	
101.00	10100 HOME HEALTH AGENCY	4,276,223	4,276,223	0	4,276,223	101.00	
SPECIAL PURPOSE COST CENTERS							
109.00	10900 PANCREAS ACQUISITION	0	0	0	0	109.00	
110.00	11000 INTESINAL ACQUISITION	0	0	0	0	110.00	
111.00	11100 ISLET ACQUISITION	0	0	0	0	111.00	
200.00	Subtotal (see instructions)	313,451,200	313,451,200	45,305	313,496,505	200.00	
201.00	Less Observation Beds	7,917,751	7,917,751	0	7,917,751	201.00	
202.00	Total (see instructions)	305,533,449	305,533,449	45,305	305,578,754	202.00	

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140213

Period:
From 10/01/2014
To 09/30/2015

Worksheet C
Part I
Date/Time Prepared:
2/19/2016 2:55 am

		Title XVII			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	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	63,936,501		63,936,501		30.00
31.00	03100	INTENSIVE CARE UNIT	18,046,777		18,046,777		31.00
40.00	04000	SUBPROVIDER - IPF	6,213,133		6,213,133		40.00
41.00	04100	SUBPROVIDER - IRF	9,541,987		9,541,987		41.00
42.00	04200	SUBPROVIDER	0		0		42.00
43.00	04300	NURSERY	9,506,097		9,506,097		43.00
44.00	04400	SKILLED NURSING FACILITY	0		0		44.00
45.00	04500	NURSING FACILITY	0		0		45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	85,614,234	102,327,765	187,941,999	0.187508	50.00
51.00	05100	RECOVERY ROOM	14,134,966	11,299,578	25,434,544	0.103628	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,545,991	908,302	9,454,293	0.717606	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	41,887,932	112,609,562	154,497,494	0.182766	54.00
54.01	05401	ULTRASOUND	7,666,618	18,479,126	26,145,744	0.101627	54.01
57.00	05700	CT SCAN	32,047,300	69,029,753	101,077,053	0.037866	57.00
58.00	05800	MRI	9,396,230	21,153,455	30,549,685	0.076218	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	67,679,084	103,187,974	170,867,058	0.075233	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	6,471,660	2,569,127	9,040,787	0.270761	63.00
65.00	06500	RESPIRATORY THERAPY	14,633,211	2,643,764	17,276,975	0.179672	65.00
65.01	06501	SLEEP LAB	0	3,143,510	3,143,510	0.167236	65.01
66.00	06600	PHYSICAL THERAPY	8,386,756	235,489	8,622,245	0.329019	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,800,310	13,086,751	18,887,061	0.235077	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	11,952,207	8,434,298	20,386,505	0.115530	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	669,485	1,902,290	2,571,775	0.246512	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	28,151,134	13,104,470	41,255,604	0.470251	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,429,276	3,917,543	16,346,819	1.302519	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	48,056,831	20,446,547	68,503,378	0.331115	73.00
74.00	07400	RENAL DIALYSIS	3,607,084	0	3,607,084	0.344421	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	09000	CLINIC	17,431	918,146	935,577	1.164342	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0.000000	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0.000000	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0	0.000000	90.03
91.00	09100	EMERGENCY	26,818,503	68,324,960	95,143,463	0.200604	91.00
91.01	09101	OP MENTAL HEALTH	0	2,250,717	2,250,717	0.481882	91.01
91.02	09102	DIABETES CENTER	63,607	332,813	396,420	1.164893	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,618,081	7,392,421	9,010,502	0.878725	92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0.000000	94.00
99.00	09900	CMHC	0	0	0		99.00
99.10	09910	CORF	0	0	0		99.10
101.00	10100	HOME HEALTH AGENCY	0	5,509,205	5,509,205		101.00
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0		109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0		110.00
111.00	11100	ISLET ACQUISITION	0	0	0		111.00
200.00		Subtotal (see instructions)	542,892,426	593,207,566	1,136,099,992		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	542,892,426	593,207,566	1,136,099,992		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140213	Period: From 10/01/2014 To 09/30/2015	Worksheet C Part I Date/Time Prepared: 2/19/2016 2:55 am
Cost Center Description		PPS Inpatient Ratio	Title XVIII	Hospital PPS
INPATIENT ROUTINE SERVICE COST CENTERS		11.00		
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
40.00	04000 SUBPROVIDER - I PF			40.00
41.00	04100 SUBPROVIDER - I RF			41.00
42.00	04200 SUBPROVIDER			42.00
43.00	04300 NURSERY			43.00
44.00	04400 SKILLED NURSING FACILITY			44.00
45.00	04500 NURSING FACILITY			45.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.187515		50.00
51.00	05100 RECOVERY ROOM	0.103628		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.717606		52.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.182766		54.00
54.01	05401 ULTRASOUND	0.101627		54.01
57.00	05700 CT SCAN	0.037866		57.00
58.00	05800 MRI	0.076218		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000 LABORATORY	0.075249		60.00
60.01	06001 BLOOD LABORATORY	0.000000		60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.270761		63.00
65.00	06500 RESPIRATORY THERAPY	0.180083		65.00
65.01	06501 SLEEP LAB	0.167236		65.01
66.00	06600 PHYSICAL THERAPY	0.329019		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.235077		67.00
68.00	06800 SPEECH PATHOLOGY	0.000000		68.00
69.00	06900 ELECTROCARDIOLOGY	0.115530		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.246512		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.470251		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1.302519		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.331115		73.00
74.00	07400 RENAL DIALYSIS	0.346214		74.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC			88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER			89.00
90.00	09000 CLINIC	1.164342		90.00
90.01	09001 HOMER GLEN LAB	0.000000		90.01
90.02	09002 HOMER GLEN FEC	0.000000		90.02
90.03	09003 WOMEN'S HEALTH	0.000000		90.03
91.00	09100 EMERGENCY	0.200868		91.00
91.01	09101 OP MENTAL HEALTH	0.481882		91.01
91.02	09102 DIABETES CENTER	1.171058		91.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.878725		92.00
OTHER REIMBURSABLE COST CENTERS				
94.00	09400 HOME PROGRAM DIALYSIS	0.000000		94.00
99.00	09900 CMHC			99.00
99.10	09910 CORF			99.10
101.00	10100 HOME HEALTH AGENCY			101.00
SPECIAL PURPOSE COST CENTERS				
109.00	10900 PANCREAS ACQUISITION			109.00
110.00	11000 INTESTINAL ACQUISITION			110.00
111.00	11100 ISLET ACQUISITION			111.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140213	Period: From 10/01/2014 To 09/30/2015	Worksheet C Part I Date/Time Prepared: 2/19/2016 2:55 am		
		Title XIX	Hospital	PPS		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs			
			Total Costs	RCE Disallowance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS		65,469,217	0	65,469,217	30.00
31.00	03100 INTENSIVE CARE UNIT		14,423,283	0	14,423,283	31.00
40.00	04000 SUBPROVIDER - I/PF		5,217,213	0	5,217,213	40.00
41.00	04100 SUBPROVIDER - I/RF		9,723,106	0	9,723,106	41.00
42.00	04200 SUBPROVIDER		0	0	0	42.00
43.00	04300 NURSERY		9,175,974	0	9,175,974	43.00
44.00	04400 SKILLED NURSING FACILITY		0	0	0	44.00
45.00	04500 NURSING FACILITY		0	0	0	45.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM		35,240,603	1,400	35,242,003	50.00
51.00	05100 RECOVERY ROOM		2,635,736	0	2,635,736	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		6,784,460	0	6,784,460	52.00
53.00	05300 ANESTHESIOLOGY		0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		28,236,907	0	28,236,907	54.00
54.01	05401 ULTRASOUND		2,657,114	0	2,657,114	54.01
57.00	05700 CT SCAN		3,827,382	0	3,827,382	57.00
58.00	05800 MRI		2,328,451	0	2,328,451	58.00
59.00	05900 CARDIAC CATHETERIZATION		0	0	0	59.00
60.00	06000 LABORATORY		12,854,761	2,778	12,857,539	60.00
60.01	06001 BLOOD LABORATORY		0	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.		2,447,890	0	2,447,890	63.00
65.00	06500 RESPIRATORY THERAPY	0	3,104,194	7,087	3,111,281	65.00
65.01	06501 SLEEP LAB	0	525,707	0	525,707	65.01
66.00	06600 PHYSICAL THERAPY	0	2,836,879	0	2,836,879	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	4,439,907	0	4,439,907	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY		2,355,249	0	2,355,249	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY		633,974	0	633,974	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		19,400,494	0	19,400,494	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		21,292,046	0	21,292,046	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		22,682,510	0	22,682,510	73.00
74.00	07400 RENAL DIALYSIS		1,242,356	6,466	1,248,822	74.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC		0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	89.00
90.00	09000 CLINIC		1,089,332	0	1,089,332	90.00
90.01	09001 HOMER GLEN LAB		0	0	0	90.01
90.02	09002 HOMER GLEN FEC		0	0	0	90.02
90.03	09003 WOMEN'S HEALTH		0	0	0	90.03
91.00	09100 EMERGENCY		19,086,113	25,130	19,111,243	91.00
91.01	09101 OP MENTAL HEALTH		1,084,581	0	1,084,581	91.01
91.02	09102 DIABETES CENTER		461,787	2,444	464,231	91.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		7,917,751	0	7,917,751	92.00
OTHER REIMBURSABLE COST CENTERS						
94.00	09400 HOME PROGRAM DIALYSIS		0	0	0	94.00
99.00	09900 CMHC		0	0	0	99.00
99.10	09910 CORF		0	0	0	99.10
101.00	10100 HOME HEALTH AGENCY		4,276,223	0	4,276,223	101.00
SPECIAL PURPOSE COST CENTERS						
109.00	10900 PANCREAS ACQUISITION		0	0	0	109.00
110.00	11000 INTestinal ACQUISITION		0	0	0	110.00
111.00	11100 ISLET ACQUISITION		0	0	0	111.00
200.00	Subtotal (see instructions)		313,451,200	45,305	313,496,505	200.00
201.00	Less Observation Beds		7,917,751	0	7,917,751	201.00
202.00	Total (see instructions)		305,533,449	45,305	305,578,754	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140213

Period:
From 10/01/2014
To 09/30/2015

Worksheet C
Part I
Date/Time Prepared:
2/19/2016 2:55 am

		Title XIX			Hospital	PPS	
Cost Center Description		Charges			Cost or Other Ratio	TEFRA Inpatient Ratio	
		Inpatient	Outpatient	Total (col. 6 + col. 7)			
		6.00	7.00	8.00			
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	63,936,501		63,936,501		30.00
31.00	03100	INTENSIVE CARE UNIT	18,046,777		18,046,777		31.00
40.00	04000	SUBPROVIDER - IPF	6,213,133		6,213,133		40.00
41.00	04100	SUBPROVIDER - IRF	9,541,987		9,541,987		41.00
42.00	04200	SUBPROVIDER	0		0		42.00
43.00	04300	NURSERY	9,506,097		9,506,097		43.00
44.00	04400	SKILLED NURSING FACILITY	0		0		44.00
45.00	04500	NURSING FACILITY	0		0		45.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	85,614,234	102,327,765	187,941,999	0.187508	50.00
51.00	05100	RECOVERY ROOM	14,134,966	11,299,578	25,434,544	0.103628	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	8,545,991	908,302	9,454,293	0.717606	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	41,887,932	112,609,562	154,497,494	0.182766	54.00
54.01	05401	ULTRASOUND	7,666,618	18,479,126	26,145,744	0.101627	54.01
57.00	05700	CT SCAN	32,047,300	69,029,753	101,077,053	0.037866	57.00
58.00	05800	MRI	9,396,230	21,153,455	30,549,685	0.076218	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	67,679,084	103,187,974	170,867,058	0.075233	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	6,471,660	2,569,127	9,040,787	0.270761	63.00
65.00	06500	RESPIRATORY THERAPY	14,633,211	2,643,764	17,276,975	0.179672	65.00
65.01	06501	SLEEP LAB	0	3,143,510	3,143,510	0.167236	65.01
66.00	06600	PHYSICAL THERAPY	8,386,756	235,489	8,622,245	0.329019	66.00
67.00	06700	OCCUPATIONAL THERAPY	5,800,310	13,086,751	18,887,061	0.235077	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	11,952,207	8,434,298	20,386,505	0.115530	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	669,485	1,902,290	2,571,775	0.246512	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	28,151,134	13,104,470	41,255,604	0.470251	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	12,429,276	3,917,543	16,346,819	1.302519	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	48,056,831	20,446,547	68,503,378	0.331115	73.00
74.00	07400	RENAL DIALYSIS	3,607,084	0	3,607,084	0.344421	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0.000000	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.000000	89.00
90.00	09000	CLINIC	17,431	918,146	935,577	1.164342	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0.000000	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0.000000	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0	0.000000	90.03
91.00	09100	EMERGENCY	26,818,503	68,324,960	95,143,463	0.200604	91.00
91.01	09101	OP MENTAL HEALTH	0	2,250,717	2,250,717	0.481882	91.01
91.02	09102	DIABETES CENTER	63,607	332,813	396,420	1.164893	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,618,081	7,392,421	9,010,502	0.878725	92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0.000000	94.00
99.00	09900	CMHC	0	0	0	0.000000	99.00
99.10	09910	CORF	0	0	0	0.000000	99.10
101.00	10100	HOME HEALTH AGENCY	0	5,509,205	5,509,205		101.00
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0		109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0		110.00
111.00	11100	ISLET ACQUISITION	0	0	0		111.00
200.00		Subtotal (see instructions)	542,892,426	593,207,566	1,136,099,992		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	542,892,426	593,207,566	1,136,099,992		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140213	Period: From 10/01/2014 To 09/30/2015	Worksheet C Part I Date/Time Prepared: 2/19/2016 2:55 am
Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital PPS
	INPATIENT ROUTINE SERVICE COST CENTERS	11.00		
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
40.00	04000 SUBPROVIDER - I PF			40.00
41.00	04100 SUBPROVIDER - I RF			41.00
42.00	04200 SUBPROVIDER			42.00
43.00	04300 NURSERY			43.00
44.00	04400 SKILLED NURSING FACILITY			44.00
45.00	04500 NURSING FACILITY			45.00
	ANCILLARY SERVICE COST CENTERS			
50.00	05000 OPERATING ROOM	0.187515		50.00
51.00	05100 RECOVERY ROOM	0.103628		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.717606		52.00
53.00	05300 ANESTHESIOLOGY	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0.182766		54.00
54.01	05401 ULTRASOUND	0.101627		54.01
57.00	05700 CT SCAN	0.037866		57.00
58.00	05800 MRI	0.076218		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000 LABORATORY	0.075249		60.00
60.01	06001 BLOOD LABORATORY	0.000000		60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0.270761		63.00
65.00	06500 RESPIRATORY THERAPY	0.180083		65.00
65.01	06501 SLEEP LAB	0.167236		65.01
66.00	06600 PHYSICAL THERAPY	0.329019		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.235077		67.00
68.00	06800 SPEECH PATHOLOGY	0.000000		68.00
69.00	06900 ELECTROCARDIOLOGY	0.115530		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.246512		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.470251		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1.302519		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.331115		73.00
74.00	07400 RENAL DIALYSIS	0.346214		74.00
	OUTPATIENT SERVICE COST CENTERS			
88.00	08800 RURAL HEALTH CLINIC	0.000000		88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
90.00	09000 CLINIC	1.164342		90.00
90.01	09001 HOMER GLEN LAB	0.000000		90.01
90.02	09002 HOMER GLEN FEC	0.000000		90.02
90.03	09003 WOMEN'S HEALTH	0.000000		90.03
91.00	09100 EMERGENCY	0.200868		91.00
91.01	09101 OP MENTAL HEALTH	0.481882		91.01
91.02	09102 DIABETES CENTER	1.171058		91.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0.878725		92.00
	OTHER REIMBURSABLE COST CENTERS			
94.00	09400 HOME PROGRAM DIALYSIS	0.000000		94.00
99.00	09900 CMHC			99.00
99.10	09910 CORF			99.10
101.00	10100 HOME HEALTH AGENCY			101.00
	SPECIAL PURPOSE COST CENTERS			
109.00	10900 PANCREAS ACQUISITION			109.00
110.00	11000 INTESTINAL ACQUISITION			110.00
111.00	11100 ISLET ACQUISITION			111.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

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

Provider CCN: 140213

Period:
From 10/01/2014
To 09/30/2015

Worksheet C
Part II
Date/Time Prepared:
2/19/2016 2:55 am

Cost Center Description		Title XIX			Hospital		PPS	
		Total Cost (Wkst. B, Part I, col. 26)	Capital Cost (Wkst. B, Part II col. 26)	Operating Cost Net of Capital Cost (col. 1 - col. 2)	Capital Reduction	Operating Cost Reduction Amount		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	35,240,603	6,912,303	28,328,300	0	0	50.00
51.00	05100	RECOVERY ROOM	2,635,736	410,908	2,224,828	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	6,784,460	642,251	6,142,209	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	28,236,907	4,932,295	23,304,612	0	0	54.00
54.01	05401	ULTRASOUND	2,657,114	480,556	2,176,558	0	0	54.01
57.00	05700	CT SCAN	3,827,382	765,929	3,061,453	0	0	57.00
58.00	05800	MRI	2,328,451	586,584	1,741,867	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	12,854,761	824,199	12,030,562	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	2,447,890	125,885	2,322,005	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	3,104,194	319,334	2,784,860	0	0	65.00
65.01	06501	SLEEP LAB	525,707	53,198	472,509	0	0	65.01
66.00	06600	PHYSICAL THERAPY	2,836,879	178,528	2,658,351	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	4,439,907	223,380	4,216,527	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	2,355,249	272,781	2,082,468	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	633,974	100,389	533,585	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	19,400,494	1,586,782	17,813,712	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	21,292,046	972,291	20,319,755	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	22,682,510	2,061,089	20,621,421	0	0	73.00
74.00	07400	RENAL DIALYSIS	1,242,356	263,901	978,455	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	1,089,332	55,585	1,033,747	0	0	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	19,086,113	3,186,559	15,899,554	0	0	91.00
91.01	09101	OP MENTAL HEALTH	1,084,581	230,595	853,986	0	0	91.01
91.02	09102	DIABETES CENTER	461,787	26,267	435,520	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	7,917,751	1,394,688	6,523,063	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
99.00	09900	CMHC	0	0	0	0	0	99.00
99.10	09910	CORF	0	0	0	0	0	99.10
101.00	10100	HOME HEALTH AGENCY	4,276,223	206,886	4,069,337	0	0	101.00
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
200.00		Subtotal (sum of lines 50 thru 199)	209,442,407	26,813,163	182,629,244	0	0	200.00
201.00		Less Observation Beds	7,917,751	1,394,688	6,523,063	0	0	201.00
202.00		Total (Line 200 minus Line 201)	201,524,656	25,418,475	176,106,181	0	0	202.00

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICAID ONLY		Provider CCN: 140213	Period: From 10/01/2014 To 09/30/2015	Worksheet C Part II Date/Time Prepared: 2/19/2016 2:55 am
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Cost Center Description		Cost Net of Capital and Operating Cost Reduction	Total Charges (Worksheet C, Part I, column 8)	Outpatient Cost to Charge Ratio (col. 6 / col. 7)	Hospital	PPS
		6.00	7.00	8.00		
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	35,240,603	187,941,999	0.187508		50.00
51.00	05100 RECOVERY ROOM	2,635,736	25,434,544	0.103628		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	6,784,460	9,454,293	0.717606		52.00
53.00	05300 ANESTHESIOLOGY	0	0	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	28,236,907	154,497,494	0.182766		54.00
54.01	05401 ULTRASOUND	2,657,114	26,145,744	0.101627		54.01
57.00	05700 CT SCAN	3,827,382	101,077,053	0.037866		57.00
58.00	05800 MRI	2,328,451	30,549,685	0.076218		58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000		59.00
60.00	06000 LABORATORY	12,854,761	170,867,058	0.075233		60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000		60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	2,447,890	9,040,787	0.270761		63.00
65.00	06500 RESPIRATORY THERAPY	3,104,194	17,276,975	0.179672		65.00
65.01	06501 SLEEP LAB	525,707	3,143,510	0.167236		65.01
66.00	06600 PHYSICAL THERAPY	2,836,879	8,622,245	0.329019		66.00
67.00	06700 OCCUPATIONAL THERAPY	4,439,907	18,887,061	0.235077		67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0.000000		68.00
69.00	06900 ELECTROCARDIOLOGY	2,355,249	20,386,505	0.115530		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	633,974	2,571,775	0.246512		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	19,400,494	41,255,604	0.470251		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	21,292,046	16,346,819	1.302519		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	22,682,510	68,503,378	0.331115		73.00
74.00	07400 RENAL DIALYSIS	1,242,356	3,607,084	0.344421		74.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	0	0.000000		88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000		89.00
90.00	09000 CLINIC	1,089,332	935,577	1.164342		90.00
90.01	09001 HOMER GLEN LAB	0	0	0.000000		90.01
90.02	09002 HOMER GLEN FEC	0	0	0.000000		90.02
90.03	09003 WOMEN'S HEALTH	0	0	0.000000		90.03
91.00	09100 EMERGENCY	19,086,113	95,143,463	0.200604		91.00
91.01	09101 OP MENTAL HEALTH	1,084,581	2,250,717	0.481882		91.01
91.02	09102 DIABETES CENTER	461,787	396,420	1.164893		91.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	7,917,751	9,010,502	0.878725		92.00
OTHER REIMBURSABLE COST CENTERS						
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0.000000		94.00
99.00	09900 CMHC	0	0	0.000000		99.00
99.10	09910 CORF	0	0	0.000000		99.10
101.00	10100 HOME HEALTH AGENCY	4,276,223	5,509,205	0.776196		101.00
SPECIAL PURPOSE COST CENTERS						
109.00	10900 PANCREAS ACQUISITION	0	0	0.000000		109.00
110.00	11000 INTESTINAL ACQUISITION	0	0	0.000000		110.00
111.00	11100 ISLET ACQUISITION	0	0	0.000000		111.00
200.00	Subtotal (sum of lines 50 thru 199)	209,442,407	1,028,855,497			200.00
201.00	Less Observation Beds	7,917,751	0			201.00
202.00	Total (line 200 minus line 201)	201,524,656	1,028,855,497			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 140213	Period: From 10/01/2014 To 09/30/2015	Worksheet D Part I Date/Time Prepared: 2/19/2016 2:55 am
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Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
	1.00	2.00	3.00	4.00	5.00	

INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	11,532,215	0	11,532,215	64,107	179.89	30.00
31.00	INTENSIVE CARE UNIT	2,189,497		2,189,497	6,700	326.79	31.00
40.00	SUBPROVIDER - IPF	992,758	0	992,758	5,521	179.81	40.00
41.00	SUBPROVIDER - IRF	1,807,626	0	1,807,626	7,411	243.91	41.00
42.00	SUBPROVIDER	0	0	0	0	0.00	42.00
43.00	NURSERY	3,244,041		3,244,041	6,735	481.67	43.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
45.00	NURSING FACILITY	0		0	0	0.00	45.00
200.00	Total (Lines 30-199)	19,766,137		19,766,137	90,474		200.00

Cost Center Description	Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
	6.00	7.00	

INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	26,985	4,854,332				30.00
31.00	INTENSIVE CARE UNIT	3,262	1,065,989				31.00
40.00	SUBPROVIDER - IPF	1,234	221,886				40.00
41.00	SUBPROVIDER - IRF	4,917	1,199,305				41.00
42.00	SUBPROVIDER	0	0				42.00
43.00	NURSERY	0	0				43.00
44.00	SKILLED NURSING FACILITY	0	0				44.00
45.00	NURSING FACILITY	0	0				45.00
200.00	Total (Lines 30-199)	36,398	7,341,512				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 140213	Period: From 10/01/2014 To 09/30/2015	Worksheet D Part II Date/Time Prepared: 2/19/2016 2:55 am
		Title XVIII	Hospital	PPS

Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	6,912,303	187,941,999	0.036779	21,705,488	798,306	50.00
51.00	05100 RECOVERY ROOM	410,908	25,434,544	0.016156	3,857,394	62,320	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	642,251	9,454,293	0.067932	14,345	974	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	4,932,295	154,497,494	0.031925	18,596,034	593,678	54.00
54.01	05401 ULTRASOUND	480,556	26,145,744	0.018380	3,954,716	72,688	54.01
57.00	05700 CT SCAN	765,929	101,077,053	0.007578	16,564,082	125,523	57.00
58.00	05800 MRI	586,584	30,549,685	0.019201	4,555,953	87,479	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000 LABORATORY	824,199	170,867,058	0.004824	33,331,106	160,789	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	125,885	9,040,787	0.013924	2,783,786	38,761	63.00
65.00	06500 RESPIRATORY THERAPY	319,334	17,276,975	0.018483	10,629,051	196,457	65.00
65.01	06501 SLEEP LAB	53,198	3,143,510	0.016923	0	0	65.01
66.00	06600 PHYSICAL THERAPY	178,528	8,622,245	0.020706	3,384,049	70,070	66.00
67.00	06700 OCCUPATIONAL THERAPY	223,380	18,887,061	0.011827	1,743,061	20,615	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	272,781	20,386,505	0.013380	6,925,748	92,667	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	100,389	2,571,775	0.039035	365,941	14,285	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1,586,782	41,255,604	0.038462	15,671,664	602,764	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	972,291	16,346,819	0.059479	12,198,004	725,525	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	2,061,089	68,503,378	0.030087	20,221,267	608,397	73.00
74.00	07400 RENAL DIALYSIS	263,901	3,607,084	0.073162	2,324,833	170,089	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000 CLINIC	55,585	935,577	0.059413	1,061	63	90.00
90.01	09001 HOMER GLEN LAB	0	0	0.000000	0	0	90.01
90.02	09002 HOMER GLEN FEC	0	0	0.000000	0	0	90.02
90.03	09003 WOMEN'S HEALTH	0	0	0.000000	0	0	90.03
91.00	09100 EMERGENCY	3,186,559	95,143,463	0.033492	13,500,815	452,169	91.00
91.01	09101 OP MENTAL HEALTH	230,595	2,250,717	0.102454	0	0	91.01
91.02	09102 DIABETES CENTER	26,267	396,420	0.066261	18,106	1,200	91.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1,394,688	9,010,502	0.154785	837,261	129,595	92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0.000000	0	0	94.00
200.00	Total (lines 50-199)	26,606,277	1,023,346,292		193,183,765	5,024,414	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 140213	Period: From 10/01/2014 To 09/30/2015	Worksheet D Part III Date/Time Prepared: 2/19/2016 2:55 am
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Cost Center Description			Title XVIII		Hospital		PPS	
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	47,864	0	0	47,864	31.00
40.00	04000	SUBPROVIDER - IPF	0	34,189	0	0	34,189	40.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	0	0	45.00
200.00		Total (lines 30-199)	0	82,053	0	0	82,053	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)	PSA Adj. Nursing School	
			6.00	7.00	8.00	9.00	11.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	64,107	0.00	26,985	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	6,700	7.14	3,262	23,291	0	31.00
40.00	04000	SUBPROVIDER - IPF	5,521	6.19	1,234	7,638	0	40.00
41.00	04100	SUBPROVIDER - IRF	7,411	0.00	4,917	0	0	41.00
42.00	04200	SUBPROVIDER	0	0.00	0	0	0	42.00
43.00	04300	NURSERY	6,735	0.00	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0.00	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0.00	0	0	0	45.00
200.00		Total (lines 30-199)	90,474	0.00	36,398	30,929	0	200.00
Cost Center Description			PSA Adj. Allied Health Cost	PSA Adj. All Other Medical Education Cost				
			12.00	13.00				
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0				30.00
31.00	03100	INTENSIVE CARE UNIT	0	0				31.00
40.00	04000	SUBPROVIDER - IPF	0	0				40.00
41.00	04100	SUBPROVIDER - IRF	0	0				41.00
42.00	04200	SUBPROVIDER	0	0				42.00
43.00	04300	NURSERY	0	0				43.00
44.00	04400	SKILLED NURSING FACILITY	0	0				44.00
45.00	04500	NURSING FACILITY	0	0				45.00
200.00		Total (lines 30-199)	0	0				200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140213	Period: From 10/01/2014 To 09/30/2015	Worksheet D Part IV Date/Time Prepared: 2/19/2016 2:55 am
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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							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	29,630	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	54.01
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	25,832	0	65.00
65.01	06501	SLEEP LAB	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	18,994	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	693,180	0	91.00
91.01	09101	OP MENTAL HEALTH	0	0	0	0	91.01
91.02	09102	DIABETES CENTER	0	0	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	94.00
200.00		Total (lines 50-199)	0	0	767,636	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140213	Period: From 10/01/2014 To 09/30/2015	Worksheet D Part IV Date/Time Prepared: 2/19/2016 2:55 am
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Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	PPS
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	187,941,999	0.000000	0.000000	21,705,488	50.00
51.00	05100 RECOVERY ROOM	0	25,434,544	0.000000	0.000000	3,857,394	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	29,630	9,454,293	0.003134	0.003134	14,345	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	154,497,494	0.000000	0.000000	18,596,034	54.00
54.01	05401 ULTRASOUND	0	26,145,744	0.000000	0.000000	3,954,716	54.01
57.00	05700 CT SCAN	0	101,077,053	0.000000	0.000000	16,564,082	57.00
58.00	05800 MRI	0	30,549,685	0.000000	0.000000	4,555,953	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000 LABORATORY	0	170,867,058	0.000000	0.000000	33,331,106	60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	9,040,787	0.000000	0.000000	2,783,786	63.00
65.00	06500 RESPIRATORY THERAPY	25,832	17,276,975	0.001495	0.001495	10,629,051	65.00
65.01	06501 SLEEP LAB	0	3,143,510	0.000000	0.000000	0	65.01
66.00	06600 PHYSICAL THERAPY	0	8,622,245	0.000000	0.000000	3,384,049	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	18,887,061	0.000000	0.000000	1,743,061	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	06900 ELECTROCARDIOLOGY	18,994	20,386,505	0.000932	0.000932	6,925,748	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	2,571,775	0.000000	0.000000	365,941	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	41,255,604	0.000000	0.000000	15,671,664	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	16,346,819	0.000000	0.000000	12,198,004	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	68,503,378	0.000000	0.000000	20,221,267	73.00
74.00	07400 RENAL DIALYSIS	0	3,607,084	0.000000	0.000000	2,324,833	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	09000 CLINIC	0	935,577	0.000000	0.000000	1,061	90.00
90.01	09001 HOMER GLEN LAB	0	0	0.000000	0.000000	0	90.01
90.02	09002 HOMER GLEN FEC	0	0	0.000000	0.000000	0	90.02
90.03	09003 WOMEN'S HEALTH	0	0	0.000000	0.000000	0	90.03
91.00	09100 EMERGENCY	693,180	95,143,463	0.007286	0.007286	13,500,815	91.00
91.01	09101 OP MENTAL HEALTH	0	2,250,717	0.000000	0.000000	0	91.01
91.02	09102 DIABETES CENTER	0	396,420	0.000000	0.000000	18,106	91.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	9,010,502	0.000000	0.000000	837,261	92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0.000000	0.000000	0	94.00
200.00	Total (lines 50-199)	767,636	1,023,346,292			193,183,765	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140213

Period:
From 10/01/2014
To 09/30/2015

Worksheet D
Part IV
Date/Time Prepared:
2/19/2016 2:55 am

Cost Center Description			Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	PPS
			11.00	12.00	13.00	21.00	22.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	17,229,436	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	1,813,939	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	45	8,888	28	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	35,869,429	0	0	0	54.00
54.01	05401	ULTRASOUND	0	2,868,457	0	0	0	54.01
57.00	05700	CT SCAN	0	17,584,962	0	0	0	57.00
58.00	05800	MRI	0	5,156,929	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	10,351,075	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	573,167	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	15,890	750,653	1,122	0	0	65.00
65.01	06501	SLEEP LAB	0	671,196	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	838	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	6,455	2,326,506	2,168	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	466,818	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	7,967,720	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,484,084	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	5,304,647	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	522,733	0	0	0	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	98,367	9,296,577	67,735	0	0	91.00
91.01	09101	OP MENTAL HEALTH	0	117,023	0	0	0	91.01
91.02	09102	DIABETES CENTER	0	32,727	0	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	2,153,283	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
200.00		Total (lines 50-199)	120,757	126,551,087	71,053	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140213	Period: From 10/01/2014 To 09/30/2015	Worksheet D Part IV Date/Time Prepared: 2/19/2016 2:55 am
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Cost Center Description		PSA Adj . Allied Health	PSA Adj . All Other Medical Education Cost	Title XVIII	Hospital	PPS
		23.00	24.00			
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0			50.00
51.00	05100 RECOVERY ROOM	0	0			51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0			52.00
53.00	05300 ANESTHESIOLOGY	0	0			53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0			54.00
54.01	05401 ULTRASOUND	0	0			54.01
57.00	05700 CT SCAN	0	0			57.00
58.00	05800 MRI	0	0			58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0			59.00
60.00	06000 LABORATORY	0	0			60.00
60.01	06001 BLOOD LABORATORY	0	0			60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0			63.00
65.00	06500 RESPIRATORY THERAPY	0	0			65.00
65.01	06501 SLEEP LAB	0	0			65.01
66.00	06600 PHYSICAL THERAPY	0	0			66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0			67.00
68.00	06800 SPEECH PATHOLOGY	0	0			68.00
69.00	06900 ELECTROCARDIOLOGY	0	0			69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0			70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	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						
88.00	08800 RURAL HEALTH CLINIC	0	0			88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0			89.00
90.00	09000 CLINIC	0	0			90.00
90.01	09001 HOMER GLEN LAB	0	0			90.01
90.02	09002 HOMER GLEN FEC	0	0			90.02
90.03	09003 WOMEN'S HEALTH	0	0			90.03
91.00	09100 EMERGENCY	0	0			91.00
91.01	09101 OP MENTAL HEALTH	0	0			91.01
91.02	09102 DIABETES CENTER	0	0			91.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0			92.00
OTHER REIMBURSABLE COST CENTERS						
94.00	09400 HOME PROGRAM DIALYSIS	0	0			94.00
200.00	Total (lines 50-199)	0	0			200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 140213	Period: From 10/01/2014 To 09/30/2015	Worksheet D Part V Date/Time Prepared: 2/19/2016 2:55 am
		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								
50.00	05000	OPERATING ROOM	0.187508	17,229,436	0	0	3,230,657	50.00
51.00	05100	RECOVERY ROOM	0.103628	1,813,939	0	0	187,975	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.717606	8,888	0	0	6,378	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.182766	35,869,429	0	1,167	6,555,712	54.00
54.01	05401	ULTRASOUND	0.101627	2,868,457	0	0	291,513	54.01
57.00	05700	CT SCAN	0.037866	17,584,962	0	5,837	665,872	57.00
58.00	05800	MRI	0.076218	5,156,929	0	1,167	393,051	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0	0	0	59.00
60.00	06000	LABORATORY	0.075233	10,351,075	1,694	0	778,742	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.270761	573,167	0	0	155,191	63.00
65.00	06500	RESPIRATORY THERAPY	0.179672	750,653	0	0	134,871	65.00
65.01	06501	SLEEP LAB	0.167236	671,196	0	0	112,248	65.01
66.00	06600	PHYSICAL THERAPY	0.329019	838	0	0	276	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.235077	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.115530	2,326,506	0	0	268,781	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.246512	466,818	0	0	115,076	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.470251	7,967,720	0	0	3,746,828	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.302519	5,484,084	51,718	0	7,143,124	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.331115	5,304,647	0	50,194	1,756,448	73.00
74.00	07400	RENAL DIALYSIS	0.344421	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0	89.00
90.00	09000	CLINIC	1.164342	522,733	0	0	608,640	90.00
90.01	09001	HOMER GLEN LAB	0.000000	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0.000000	0	0	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0.000000	0	0	0	0	90.03
91.00	09100	EMERGENCY	0.200604	9,296,577	0	0	1,864,931	91.00
91.01	09101	OP MENTAL HEALTH	0.481882	117,023	0	0	56,391	91.01
91.02	09102	DIABETES CENTER	1.164893	32,727	0	0	38,123	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.878725	2,153,283	0	0	1,892,144	92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0.000000		0			94.00
200.00		Subtotal (see instructions)		126,551,087	53,412	58,365	30,002,972	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		126,551,087	53,412	58,365	30,002,972	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 140213	Period: From 10/01/2014 To 09/30/2015	Worksheet D Part V Date/Time Prepared: 2/19/2016 2:55 am
	Title XVIII	Hospital	PPS

Cost Center Description	Costs		Hospital	PPS
	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				
50.00 05000 OPERATING ROOM	0	0		50.00
51.00 05100 RECOVERY ROOM	0	0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00 05300 ANESTHESIOLOGY	0	0		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	213		54.00
54.01 05401 ULTRASOUND	0	0		54.01
57.00 05700 CT SCAN	0	221		57.00
58.00 05800 MRI	0	89		58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0		59.00
60.00 06000 LABORATORY	127	0		60.00
60.01 06001 BLOOD LABORATORY	0	0		60.01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
65.00 06500 RESPIRATORY THERAPY	0	0		65.00
65.01 06501 SLEEP LAB	0	0		65.01
66.00 06600 PHYSICAL THERAPY	0	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	0		68.00
69.00 06900 ELECTROCARDIOLOGY	0	0		69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	67,364	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	16,620		73.00
74.00 07400 RENAL DIALYSIS	0	0		74.00
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC	0	0		88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00 09000 CLINIC	0	0		90.00
90.01 09001 HOMER GLEN LAB	0	0		90.01
90.02 09002 HOMER GLEN FEC	0	0		90.02
90.03 09003 WOMEN'S HEALTH	0	0		90.03
91.00 09100 EMERGENCY	0	0		91.00
91.01 09101 OP MENTAL HEALTH	0	0		91.01
91.02 09102 DIABETES CENTER	0	0		91.02
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
OTHER REIMBURSABLE COST CENTERS				
94.00 09400 HOME PROGRAM DIALYSIS	0	0		94.00
200.00	Subtotal (see instructions)	67,491	17,143	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 +/- line 201)	67,491	17,143	202.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 140213 Component CCN: 14S213		Period: From 10/01/2014 To 09/30/2015		Worksheet D Part II Date/Time Prepared: 2/19/2016 2:55 am		
		Title XVIII		Subprovider - IPF		PPS		
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 + col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	6,912,303	187,941,999	0.036779	19,484	717	50.00
51.00	05100	RECOVERY ROOM	410,908	25,434,544	0.016156	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	642,251	9,454,293	0.067932	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,932,295	154,497,494	0.031925	17,145	547	54.00
54.01	05401	ULTRASOUND	480,556	26,145,744	0.018380	8,506	156	54.01
57.00	05700	CT SCAN	765,929	101,077,053	0.007578	21,312	162	57.00
58.00	05800	MRI	586,584	30,549,685	0.019201	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	824,199	170,867,058	0.004824	281,020	1,356	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	125,885	9,040,787	0.013924	7,614	106	63.00
65.00	06500	RESPIRATORY THERAPY	319,334	17,276,975	0.018483	23,900	442	65.00
65.01	06501	SLEEP LAB	53,198	3,143,510	0.016923	0	0	65.01
66.00	06600	PHYSICAL THERAPY	178,528	8,622,245	0.020706	10,160	210	66.00
67.00	06700	OCCUPATIONAL THERAPY	223,380	18,887,061	0.011827	3,825	45	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	272,781	20,386,505	0.013380	13,940	187	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	100,389	2,571,775	0.039035	625	24	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,586,782	41,255,604	0.038462	867	33	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	972,291	16,346,819	0.059479	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,061,089	68,503,378	0.030087	174,223	5,242	73.00
74.00	07400	RENAL DIALYSIS	263,901	3,607,084	0.073162	3,261	239	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	55,585	935,577	0.059413	0	0	90.00
90.01	09001	HOMER GLEN LAB	0	0	0.000000	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0.000000	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0.000000	0	0	90.03
91.00	09100	EMERGENCY	3,186,559	95,143,463	0.033492	207,082	6,936	91.00
91.01	09101	OP MENTAL HEALTH	230,595	2,250,717	0.102454	0	0	91.01
91.02	09102	DIABETES CENTER	26,267	396,420	0.066261	1,195	79	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	9,010,502	0.000000	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0.000000	0	0	94.00
200.00		Total (lines 50-199)	25,211,589	1,023,346,292		794,159	16,481	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140213 Component CCN: 14S213	Period: From 10/01/2014 To 09/30/2015	Worksheet D Part IV Date/Time Prepared: 2/19/2016 2:55 am
	Title XVIII	Subprovider - IPF	PPS

Cost Center Description		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	29,630	0	29,630	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401 ULTRASOUND	0	0	0	0	0	54.01
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MRI	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0	0	25,832	0	25,832	65.00
65.01	06501 SLEEP LAB	0	0	0	0	0	65.01
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	18,994	0	18,994	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000 CLINIC	0	0	0	0	0	90.00
90.01	09001 HOMER GLEN LAB	0	0	0	0	0	90.01
90.02	09002 HOMER GLEN FEC	0	0	0	0	0	90.02
90.03	09003 WOMEN'S HEALTH	0	0	0	0	0	90.03
91.00	09100 EMERGENCY	0	0	693,180	0	693,180	91.00
91.01	09101 OP MENTAL HEALTH	0	0	0	0	0	91.01
91.02	09102 DIABETES CENTER	0	0	0	0	0	91.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
200.00	Total (lines 50-199)	0	0	767,636	0	767,636	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140213 Component CCN: 14S213	Period: From 10/01/2014 To 09/30/2015	Worksheet D Part IV Date/Time Prepared: 2/19/2016 2:55 am
	Title XVIII	Subprovider - IPF	PPS

Cost Center Description	Total	Total Charges	Ratio of Cost	Outpatient	Inpatient Program Charges	
	Outpatient Cost (sum of col. 2, 3 and 4)	(from Wkst. C, Part I, col. 8)	to Charges (col. 5 + col. 7)	Ratio of Cost to Charges (col. 6 ÷ col. 7)		
	6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	187,941,999	0.000000	0.000000	19,484	50.00
51.00 05100 RECOVERY ROOM	0	25,434,544	0.000000	0.000000	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	29,630	9,454,293	0.003134	0.003134	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	154,497,494	0.000000	0.000000	17,145	54.00
54.01 05401 ULTRASOUND	0	26,145,744	0.000000	0.000000	8,506	54.01
57.00 05700 CT SCAN	0	101,077,053	0.000000	0.000000	21,312	57.00
58.00 05800 MRI	0	30,549,685	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	170,867,058	0.000000	0.000000	281,020	60.00
60.01 06001 BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	9,040,787	0.000000	0.000000	7,614	63.00
65.00 06500 RESPIRATORY THERAPY	25,832	17,276,975	0.001495	0.001495	23,900	65.00
65.01 06501 SLEEP LAB	0	3,143,510	0.000000	0.000000	0	65.01
66.00 06600 PHYSICAL THERAPY	0	8,622,245	0.000000	0.000000	10,160	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	18,887,061	0.000000	0.000000	3,825	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00 06900 ELECTROCARDIOLOGY	18,994	20,386,505	0.000932	0.000932	13,940	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	2,571,775	0.000000	0.000000	625	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	41,255,604	0.000000	0.000000	867	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	16,346,819	0.000000	0.000000	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	68,503,378	0.000000	0.000000	174,223	73.00
74.00 07400 RENAL DIALYSIS	0	3,607,084	0.000000	0.000000	3,261	74.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00 09000 CLINIC	0	935,577	0.000000	0.000000	0	90.00
90.01 09001 HOMER GLEN LAB	0	0	0.000000	0.000000	0	90.01
90.02 09002 HOMER GLEN FEC	0	0	0.000000	0.000000	0	90.02
90.03 09003 WOMEN'S HEALTH	0	0	0.000000	0.000000	0	90.03
91.00 09100 EMERGENCY	693,180	95,143,463	0.007286	0.007286	207,082	91.00
91.01 09101 OP MENTAL HEALTH	0	2,250,717	0.000000	0.000000	0	91.01
91.02 09102 DIABETES CENTER	0	396,420	0.000000	0.000000	1,195	91.02
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	9,010,502	0.000000	0.000000	0	92.00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0.000000	0.000000	0	94.00
200.00 Total (lines 50-199)	767,636	1,023,346,292			794,159	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140213 Component CCN: 14S213	Period: From 10/01/2014 To 09/30/2015	Worksheet D Part IV Date/Time Prepared: 2/19/2016 2:55 am
Title XVIII		Subprovider - IPF	PPS

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
		11.00	12.00	13.00	21.00	22.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401 ULTRASOUND	0	0	0	0	0	54.01
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MRI	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	36	0	0	0	0	65.00
65.01	06501 SLEEP LAB	0	0	0	0	0	65.01
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	13	0	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000 CLINIC	0	0	0	0	0	90.00
90.01	09001 HOMER GLEN LAB	0	0	0	0	0	90.01
90.02	09002 HOMER GLEN FEC	0	0	0	0	0	90.02
90.03	09003 WOMEN'S HEALTH	0	0	0	0	0	90.03
91.00	09100 EMERGENCY	1,509	0	0	0	0	91.00
91.01	09101 OP MENTAL HEALTH	0	0	0	0	0	91.01
91.02	09102 DIABETES CENTER	0	0	0	0	0	91.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
200.00	Total (lines 50-199)	1,558	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140213	Period: From 10/01/2014 To 09/30/2015	Worksheet D Part IV Date/Time Prepared: 2/19/2016 2:55 am
	Component CCN: 14S213	Title XVII I	Subprovider - IPF PPS

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

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 140213 Component CCN: 14T213		Period: From 10/01/2014 To 09/30/2015		Worksheet D Part II Date/Time Prepared: 2/19/2016 2:55 am		
		Title XVIII		Subprovider - IRF		PPS		
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 + col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)		
		1.00	2.00	3.00	4.00	5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	6,912,303	187,941,999	0.036779	200,654	7,380	50.00
51.00	05100	RECOVERY ROOM	410,908	25,434,544	0.016156	14,923	241	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	642,251	9,454,293	0.067932	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,932,295	154,497,494	0.031925	222,581	7,106	54.00
54.01	05401	ULTRASOUND	480,556	26,145,744	0.018380	97,853	1,799	54.01
57.00	05700	CT SCAN	765,929	101,077,053	0.007578	169,661	1,286	57.00
58.00	05800	MRI	586,584	30,549,685	0.019201	86,293	1,657	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	824,199	170,867,058	0.004824	1,002,627	4,837	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	125,885	9,040,787	0.013924	82,625	1,150	63.00
65.00	06500	RESPIRATORY THERAPY	319,334	17,276,975	0.018483	560,713	10,364	65.00
65.01	06501	SLEEP LAB	53,198	3,143,510	0.016923	0	0	65.01
66.00	06600	PHYSICAL THERAPY	178,528	8,622,245	0.020706	2,577,591	53,372	66.00
67.00	06700	OCCUPATIONAL THERAPY	223,380	18,887,061	0.011827	2,387,925	28,242	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	272,781	20,386,505	0.013380	49,728	665	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	100,389	2,571,775	0.039035	14,358	560	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,586,782	41,255,604	0.038462	283,012	10,885	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	972,291	16,346,819	0.059479	22,266	1,324	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,061,089	68,503,378	0.030087	1,024,593	30,827	73.00
74.00	07400	RENAL DIALYSIS	263,901	3,607,084	0.073162	102,698	7,514	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	55,585	935,577	0.059413	0	0	90.00
90.01	09001	HOMER GLEN LAB	0	0	0.000000	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0.000000	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0.000000	0	0	90.03
91.00	09100	EMERGENCY	3,186,559	95,143,463	0.033492	195	7	91.00
91.01	09101	OP MENTAL HEALTH	230,595	2,250,717	0.102454	0	0	91.01
91.02	09102	DIABETES CENTER	26,267	396,420	0.066261	1,655	110	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	9,010,502	0.000000	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0.000000	0	0	94.00
200.00		Total (lines 50-199)	25,211,589	1,023,346,292		8,901,951	169,326	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140213 Component CCN: 14T213	Period: From 10/01/2014 To 09/30/2015	Worksheet D Part IV Date/Time Prepared: 2/19/2016 2:55 am
	Title XVIII	Subprovider - IRF	PPS

Cost Center Description		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	29,630	0	29,630	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401 ULTRASOUND	0	0	0	0	0	54.01
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MRI	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0	0	25,832	0	25,832	65.00
65.01	06501 SLEEP LAB	0	0	0	0	0	65.01
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	18,994	0	18,994	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000 CLINIC	0	0	0	0	0	90.00
90.01	09001 HOMER GLEN LAB	0	0	0	0	0	90.01
90.02	09002 HOMER GLEN FEC	0	0	0	0	0	90.02
90.03	09003 WOMEN'S HEALTH	0	0	0	0	0	90.03
91.00	09100 EMERGENCY	0	0	693,180	0	693,180	91.00
91.01	09101 OP MENTAL HEALTH	0	0	0	0	0	91.01
91.02	09102 DIABETES CENTER	0	0	0	0	0	91.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
200.00	Total (lines 50-199)	0	0	767,636	0	767,636	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 140213 Component CCN: 14T213		Period: From 10/01/2014 To 09/30/2015		Worksheet D Part IV Date/Time Prepared: 2/19/2016 2:55 am		
				Title XVIII		Subprovider - IRF	PPS	
Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	187,941,999	0.000000	0.000000	200,654	50.00
51.00	05100	RECOVERY ROOM	0	25,434,544	0.000000	0.000000	14,923	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	29,630	9,454,293	0.003134	0.003134	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	154,497,494	0.000000	0.000000	222,581	54.00
54.01	05401	ULTRASOUND	0	26,145,744	0.000000	0.000000	97,853	54.01
57.00	05700	CT SCAN	0	101,077,053	0.000000	0.000000	169,661	57.00
58.00	05800	MRI	0	30,549,685	0.000000	0.000000	86,293	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	170,867,058	0.000000	0.000000	1,002,627	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	9,040,787	0.000000	0.000000	82,625	63.00
65.00	06500	RESPIRATORY THERAPY	25,832	17,276,975	0.001495	0.001495	560,713	65.00
65.01	06501	SLEEP LAB	0	3,143,510	0.000000	0.000000	0	65.01
66.00	06600	PHYSICAL THERAPY	0	8,622,245	0.000000	0.000000	2,577,591	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	18,887,061	0.000000	0.000000	2,387,925	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	18,994	20,386,505	0.000932	0.000932	49,728	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2,571,775	0.000000	0.000000	14,358	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	41,255,604	0.000000	0.000000	283,012	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	16,346,819	0.000000	0.000000	22,266	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	68,503,378	0.000000	0.000000	1,024,593	73.00
74.00	07400	RENAL DIALYSIS	0	3,607,084	0.000000	0.000000	102,698	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	09000	CLINIC	0	935,577	0.000000	0.000000	0	90.00
90.01	09001	HOMER GLEN LAB	0	0	0.000000	0.000000	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0.000000	0.000000	0	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0.000000	0.000000	0	90.03
91.00	09100	EMERGENCY	693,180	95,143,463	0.007286	0.007286	195	91.00
91.01	09101	OP MENTAL HEALTH	0	2,250,717	0.000000	0.000000	0	91.01
91.02	09102	DIABETES CENTER	0	396,420	0.000000	0.000000	1,655	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	9,010,502	0.000000	0.000000	0	92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0.000000	0.000000	0	94.00
200.00		Total (lines 50-199)	767,636	1,023,346,292			8,901,951	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140213 Component CCN: 14T213	Period: From 10/01/2014 To 09/30/2015	Worksheet D Part IV Date/Time Prepared: 2/19/2016 2:55 am
Title XVIII		Subprovider - IRF	PPS

Cost Center Description		Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12)	PSA Adj. Non Physician Anesthetist Cost	PSA Adj. Nursing School	
		11.00	12.00	13.00	21.00	22.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401 ULTRASOUND	0	0	0	0	0	54.01
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MRI	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	838	0	0	0	0	65.00
65.01	06501 SLEEP LAB	0	0	0	0	0	65.01
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	46	0	0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000 CLINIC	0	0	0	0	0	90.00
90.01	09001 HOMER GLEN LAB	0	0	0	0	0	90.01
90.02	09002 HOMER GLEN FEC	0	0	0	0	0	90.02
90.03	09003 WOMEN'S HEALTH	0	0	0	0	0	90.03
91.00	09100 EMERGENCY	1	0	0	0	0	91.00
91.01	09101 OP MENTAL HEALTH	0	0	0	0	0	91.01
91.02	09102 DIABETES CENTER	0	0	0	0	0	91.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
200.00	Total (lines 50-199)	885	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140213 Component CCN: 14T213	Period: From 10/01/2014 To 09/30/2015	Worksheet D Part IV Date/Time Prepared: 2/19/2016 2:55 am
	Title XVII I	Subprovider - IRF	PPS

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

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 140213	Period: From 10/01/2014 To 09/30/2015	Worksheet D Part I Date/Time Prepared: 2/19/2016 2:55 am
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Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
	1.00	2.00	3.00	4.00	5.00	

INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	ADULTS & PEDIATRICS	11,532,215	0	11,532,215	64,107	179.89	30.00
31.00	INTENSIVE CARE UNIT	2,189,497		2,189,497	6,700	326.79	31.00
40.00	SUBPROVIDER - IPF	992,758	0	992,758	5,521	179.81	40.00
41.00	SUBPROVIDER - IRF	1,807,626	0	1,807,626	7,411	243.91	41.00
42.00	SUBPROVIDER	0	0	0	0	0.00	42.00
43.00	NURSERY	3,244,041		3,244,041	6,735	481.67	43.00
44.00	SKILLED NURSING FACILITY	0		0	0	0.00	44.00
45.00	NURSING FACILITY	0		0	0	0.00	45.00
200.00	Total (lines 30-199)	19,766,137		19,766,137	90,474		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	6,948	1,249,876				30.00
31.00	INTENSIVE CARE UNIT	965	315,352				31.00
40.00	SUBPROVIDER - IPF	1,174	211,097				40.00
41.00	SUBPROVIDER - IRF	178	43,416				41.00
42.00	SUBPROVIDER	0	0				42.00
43.00	NURSERY	970	467,220				43.00
44.00	SKILLED NURSING FACILITY	0	0				44.00
45.00	NURSING FACILITY	0	0				45.00
200.00	Total (lines 30-199)	10,235	2,286,961				200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS

Provider CCN: 140213

Period:
From 10/01/2014
To 09/30/2015

Worksheet D
Part II
Date/Time Prepared:
2/19/2016 2:55 am

Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	6,912,303	187,941,999	0.036779	0	0	50.00
51.00	05100	RECOVERY ROOM	410,908	25,434,544	0.016156	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	642,251	9,454,293	0.067932	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,932,295	154,497,494	0.031925	0	0	54.00
54.01	05401	ULTRASOUND	480,556	26,145,744	0.018380	0	0	54.01
57.00	05700	CT SCAN	765,929	101,077,053	0.007578	0	0	57.00
58.00	05800	MRI	586,584	30,549,685	0.019201	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	824,199	170,867,058	0.004824	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	125,885	9,040,787	0.013924	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	319,334	17,276,975	0.018483	0	0	65.00
65.01	06501	SLEEP LAB	53,198	3,143,510	0.016923	0	0	65.01
66.00	06600	PHYSICAL THERAPY	178,528	8,622,245	0.020706	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	223,380	18,887,061	0.011827	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	272,781	20,386,505	0.013380	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	100,389	2,571,775	0.039035	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,586,782	41,255,604	0.038462	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	972,291	16,346,819	0.059479	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,061,089	68,503,378	0.030087	0	0	73.00
74.00	07400	RENAL DIALYSIS	263,901	3,607,084	0.073162	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	55,585	935,577	0.059413	0	0	90.00
90.01	09001	HOMER GLEN LAB	0	0	0.000000	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0.000000	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0.000000	0	0	90.03
91.00	09100	EMERGENCY	3,186,559	95,143,463	0.033492	0	0	91.00
91.01	09101	OP MENTAL HEALTH	230,595	2,250,717	0.102454	0	0	91.01
91.02	09102	DIABETES CENTER	26,267	396,420	0.066261	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,394,688	9,010,502	0.154785	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0.000000	0	0	94.00
200.00		Total (lines 50-199)	26,606,277	1,023,346,292		0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 140213	Period: From 10/01/2014 To 09/30/2015	Worksheet D Part III Date/Time Prepared: 2/19/2016 2:55 am
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Cost Center Description	Title XIX			Hospital	PPS
	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	30.00
31.00	03100	INTENSIVE CARE UNIT	0	47,864	0	31.00
40.00	04000	SUBPROVIDER - I PF	0	34,189	0	40.00
41.00	04100	SUBPROVIDER - I RF	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0	0	44.00
45.00	04500	NURSING FACILITY	0	0	0	45.00
200.00		Total (lines 30-199)	0	82,053	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)	PSA Adj. Nursing School
	6.00	7.00	8.00	9.00	11.00

INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	64,107	0.00	6,948	0	30.00
31.00	03100	INTENSIVE CARE UNIT	6,700	7.14	965	6,890	31.00
40.00	04000	SUBPROVIDER - I PF	5,521	6.19	1,174	7,267	40.00
41.00	04100	SUBPROVIDER - I RF	7,411	0.00	178	0	41.00
42.00	04200	SUBPROVIDER	0	0.00	0	0	42.00
43.00	04300	NURSERY	6,735	0.00	970	0	43.00
44.00	04400	SKILLED NURSING FACILITY	0	0.00	0	0	44.00
45.00	04500	NURSING FACILITY	0	0.00	0	0	45.00
200.00		Total (lines 30-199)	90,474	0.00	10,235	14,157	200.00

Cost Center Description	PSA Adj. Allied Health Cost	PSA Adj. All Other Medical Education Cost
	12.00	13.00

INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS	0	0		30.00
31.00	03100	INTENSIVE CARE UNIT	0	0		31.00
40.00	04000	SUBPROVIDER - I PF	0	0		40.00
41.00	04100	SUBPROVIDER - I RF	0	0		41.00
42.00	04200	SUBPROVIDER	0	0		42.00
43.00	04300	NURSERY	0	0		43.00
44.00	04400	SKILLED NURSING FACILITY	0	0		44.00
45.00	04500	NURSING FACILITY	0	0		45.00
200.00		Total (lines 30-199)	0	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140213	Period: From 10/01/2014 To 09/30/2015	Worksheet D Part IV Date/Time Prepared: 2/19/2016 2:55 am
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Cost Center Description	Title XIX				Hospital	PPS	Total Cost (sum of col 1 through col . 4)	
	Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost				
	1.00	2.00	3.00	4.00		5.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	29,630	0	29,630	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401	ULTRASOUND	0	0	0	0	0	54.01
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MRI	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	0	0	25,832	0	25,832	65.00
65.01	06501	SLEEP LAB	0	0	0	0	0	65.01
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	18,994	0	18,994	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	0	90.00
90.01	09001	HOMER GLEN LAB	0	0	0	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0	0	0	90.03
91.00	09100	EMERGENCY	0	0	693,180	0	693,180	91.00
91.01	09101	OP MENTAL HEALTH	0	0	0	0	0	91.01
91.02	09102	DIABETES CENTER	0	0	0	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
200.00		Total (lines 50-199)	0	0	767,636	0	767,636	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140213

Period:
From 10/01/2014
To 09/30/2015

Worksheet D
Part IV
Date/Time Prepared:
2/19/2016 2:55 am

Cost Center Description		Title XIX			Hospital		PPS	
		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	187,941,999	0.000000	0.000000	0	50.00
51.00	05100	RECOVERY ROOM	0	25,434,544	0.000000	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	29,630	9,454,293	0.003134	0.003134	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	154,497,494	0.000000	0.000000	0	54.00
54.01	05401	ULTRASOUND	0	26,145,744	0.000000	0.000000	0	54.01
57.00	05700	CT SCAN	0	101,077,053	0.000000	0.000000	0	57.00
58.00	05800	MRI	0	30,549,685	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	170,867,058	0.000000	0.000000	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	9,040,787	0.000000	0.000000	0	63.00
65.00	06500	RESPIRATORY THERAPY	25,832	17,276,975	0.001495	0.001495	0	65.00
65.01	06501	SLEEP LAB	0	3,143,510	0.000000	0.000000	0	65.01
66.00	06600	PHYSICAL THERAPY	0	8,622,245	0.000000	0.000000	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	18,887,061	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	18,994	20,386,505	0.000932	0.000932	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	2,571,775	0.000000	0.000000	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	41,255,604	0.000000	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	16,346,819	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	68,503,378	0.000000	0.000000	0	73.00
74.00	07400	RENAL DIALYSIS	0	3,607,084	0.000000	0.000000	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	09000	CLINIC	0	935,577	0.000000	0.000000	0	90.00
90.01	09001	HOMER GLEN LAB	0	0	0.000000	0.000000	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0.000000	0.000000	0	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0.000000	0.000000	0	90.03
91.00	09100	EMERGENCY	693,180	95,143,463	0.007286	0.007286	0	91.00
91.01	09101	OP MENTAL HEALTH	0	2,250,717	0.000000	0.000000	0	91.01
91.02	09102	DIABETES CENTER	0	396,420	0.000000	0.000000	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	9,010,502	0.000000	0.000000	0	92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0.000000	0.000000	0	94.00
200.00		Total (lines 50-199)	767,636	1,023,346,292			0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140213

Period:
From 10/01/2014
To 09/30/2015

Worksheet D
Part IV
Date/Time Prepared:
2/19/2016 2:55 am

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140213	Period: From 10/01/2014 To 09/30/2015	Worksheet D Part IV Date/Time Prepared: 2/19/2016 2:55 am
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Cost Center Description		PSA Adj. Allied Health	PSA Adj. All Other Medical Education Cost	Title XIX	Hospital	PPS
		23.00	24.00			
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM	0	0		50.00
51.00	05100	RECOVERY ROOM	0	0		51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52.00
53.00	05300	ANESTHESIOLOGY	0	0		53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0		54.00
54.01	05401	ULTRASOUND	0	0		54.01
57.00	05700	CT SCAN	0	0		57.00
58.00	05800	MRI	0	0		58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0		59.00
60.00	06000	LABORATORY	0	0		60.00
60.01	06001	BLOOD LABORATORY	0	0		60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
65.00	06500	RESPIRATORY THERAPY	0	0		65.00
65.01	06501	SLEEP LAB	0	0		65.01
66.00	06600	PHYSICAL THERAPY	0	0		66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800	SPEECH PATHOLOGY	0	0		68.00
69.00	06900	ELECTROCARDIOLOGY	0	0		69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	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						
88.00	08800	RURAL HEALTH CLINIC	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		89.00
90.00	09000	CLINIC	0	0		90.00
90.01	09001	HOMER GLEN LAB	0	0		90.01
90.02	09002	HOMER GLEN FEC	0	0		90.02
90.03	09003	WOMEN'S HEALTH	0	0		90.03
91.00	09100	EMERGENCY	0	0		91.00
91.01	09101	OP MENTAL HEALTH	0	0		91.01
91.02	09102	DIABETES CENTER	0	0		91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
OTHER REIMBURSABLE COST CENTERS						
94.00	09400	HOME PROGRAM DIALYSIS	0	0		94.00
200.00		Total (lines 50-199)	0	0		200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 140213 Component CCN: 14S213		Period: From 10/01/2014 To 09/30/2015		Worksheet D Part II Date/Time Prepared: 2/19/2016 2:55 am	
				Title XIX		Subprovider - IPF	PPS
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 + col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	6,912,303	187,941,999	0.036779	0	50.00
51.00	05100	RECOVERY ROOM	410,908	25,434,544	0.016156	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	642,251	9,454,293	0.067932	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,932,295	154,497,494	0.031925	0	54.00
54.01	05401	ULTRASOUND	480,556	26,145,744	0.018380	0	54.01
57.00	05700	CT SCAN	765,929	101,077,053	0.007578	0	57.00
58.00	05800	MRI	586,584	30,549,685	0.019201	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	59.00
60.00	06000	LABORATORY	824,199	170,867,058	0.004824	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	125,885	9,040,787	0.013924	0	63.00
65.00	06500	RESPIRATORY THERAPY	319,334	17,276,975	0.018483	0	65.00
65.01	06501	SLEEP LAB	53,198	3,143,510	0.016923	0	65.01
66.00	06600	PHYSICAL THERAPY	178,528	8,622,245	0.020706	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	223,380	18,887,061	0.011827	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	272,781	20,386,505	0.013380	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	100,389	2,571,775	0.039035	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,586,782	41,255,604	0.038462	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	972,291	16,346,819	0.059479	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,061,089	68,503,378	0.030087	0	73.00
74.00	07400	RENAL DIALYSIS	263,901	3,607,084	0.073162	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	89.00
90.00	09000	CLINIC	55,585	935,577	0.059413	0	90.00
90.01	09001	HOMER GLEN LAB	0	0	0.000000	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0.000000	0	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0.000000	0	90.03
91.00	09100	EMERGENCY	3,186,559	95,143,463	0.033492	0	91.00
91.01	09101	OP MENTAL HEALTH	230,595	2,250,717	0.102454	0	91.01
91.02	09102	DIABETES CENTER	26,267	396,420	0.066261	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	9,010,502	0.000000	0	92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0.000000	0	94.00
200.00		Total (lines 50-199)	25,211,589	1,023,346,292		0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140213 Component CCN: 14S213	Period: From 10/01/2014 To 09/30/2015	Worksheet D Part IV Date/Time Prepared: 2/19/2016 2:55 am
	Title XIX	Subprovider - IPF	PPS

Cost Center Description		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	29,630	0	29,630	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401 ULTRASOUND	0	0	0	0	0	54.01
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MRI	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0	0	25,832	0	25,832	65.00
65.01	06501 SLEEP LAB	0	0	0	0	0	65.01
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	18,994	0	18,994	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000 CLINIC	0	0	0	0	0	90.00
90.01	09001 HOMER GLEN LAB	0	0	0	0	0	90.01
90.02	09002 HOMER GLEN FEC	0	0	0	0	0	90.02
90.03	09003 WOMEN'S HEALTH	0	0	0	0	0	90.03
91.00	09100 EMERGENCY	0	0	693,180	0	693,180	91.00
91.01	09101 OP MENTAL HEALTH	0	0	0	0	0	91.01
91.02	09102 DIABETES CENTER	0	0	0	0	0	91.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
200.00	Total (lines 50-199)	0	0	767,636	0	767,636	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140213 Component CCN: 14S213	Period: From 10/01/2014 To 09/30/2015	Worksheet D Part IV Date/Time Prepared: 2/19/2016 2:55 am
	Title XIX	Subprovider - IPF	PPS

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	187,941,999	0.000000	0.000000		0 50.00
51.00	05100 RECOVERY ROOM	0	25,434,544	0.000000	0.000000		0 51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	29,630	9,454,293	0.003134	0.003134		0 52.00
53.00	05300 ANESTHESIOLOGY	0	0	0.000000	0.000000		0 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	154,497,494	0.000000	0.000000		0 54.00
54.01	05401 ULTRASOUND	0	26,145,744	0.000000	0.000000		0 54.01
57.00	05700 CT SCAN	0	101,077,053	0.000000	0.000000		0 57.00
58.00	05800 MRI	0	30,549,685	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	170,867,058	0.000000	0.000000		0 60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0.000000		0 60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	9,040,787	0.000000	0.000000		0 63.00
65.00	06500 RESPIRATORY THERAPY	25,832	17,276,975	0.001495	0.001495		0 65.00
65.01	06501 SLEEP LAB	0	3,143,510	0.000000	0.000000		0 65.01
66.00	06600 PHYSICAL THERAPY	0	8,622,245	0.000000	0.000000		0 66.00
67.00	06700 OCCUPATIONAL THERAPY	0	18,887,061	0.000000	0.000000		0 67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0.000000	0.000000		0 68.00
69.00	06900 ELECTROCARDIOLOGY	18,994	20,386,505	0.000932	0.000932		0 69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	2,571,775	0.000000	0.000000		0 70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	41,255,604	0.000000	0.000000		0 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	16,346,819	0.000000	0.000000		0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	68,503,378	0.000000	0.000000		0 73.00
74.00	07400 RENAL DIALYSIS	0	3,607,084	0.000000	0.000000		0 74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	0	0.000000	0.000000		0 88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000		0 89.00
90.00	09000 CLINIC	0	935,577	0.000000	0.000000		0 90.00
90.01	09001 HOMER GLEN LAB	0	0	0.000000	0.000000		0 90.01
90.02	09002 HOMER GLEN FEC	0	0	0.000000	0.000000		0 90.02
90.03	09003 WOMEN'S HEALTH	0	0	0.000000	0.000000		0 90.03
91.00	09100 EMERGENCY	693,180	95,143,463	0.007286	0.007286		0 91.00
91.01	09101 OP MENTAL HEALTH	0	2,250,717	0.000000	0.000000		0 91.01
91.02	09102 DIABETES CENTER	0	396,420	0.000000	0.000000		0 91.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	9,010,502	0.000000	0.000000		0 92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0.000000	0.000000		0 94.00
200.00	Total (lines 50-199)	767,636	1,023,346,292				0 200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140213 Component CCN: 14S213	Period: From 10/01/2014 To 09/30/2015	Worksheet D Part IV Date/Time Prepared: 2/19/2016 2:55 am
Title XIX		Subprovider - IPF	PPS

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140213 Component CCN: 14S213	Period: From 10/01/2014 To 09/30/2015	Worksheet D Part IV Date/Time Prepared: 2/19/2016 2:55 am
Title XIX		Subprovider - IPF	PPS

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

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS			Provider CCN: 140213 Component CCN: 14T213		Period: From 10/01/2014 To 09/30/2015		Worksheet D Part II Date/Time Prepared: 2/19/2016 2:55 am	
			Title XIX		Subprovider - IRF		PPS	
Cost Center Description			Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 + col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
			1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	6,912,303	187,941,999	0.036779	0	0	50.00
51.00	05100	RECOVERY ROOM	410,908	25,434,544	0.016156	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	642,251	9,454,293	0.067932	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0.000000	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	4,932,295	154,497,494	0.031925	0	0	54.00
54.01	05401	ULTRASOUND	480,556	26,145,744	0.018380	0	0	54.01
57.00	05700	CT SCAN	765,929	101,077,053	0.007578	0	0	57.00
58.00	05800	MRI	586,584	30,549,685	0.019201	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000	LABORATORY	824,199	170,867,058	0.004824	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	125,885	9,040,787	0.013924	0	0	63.00
65.00	06500	RESPIRATORY THERAPY	319,334	17,276,975	0.018483	0	0	65.00
65.01	06501	SLEEP LAB	53,198	3,143,510	0.016923	0	0	65.01
66.00	06600	PHYSICAL THERAPY	178,528	8,622,245	0.020706	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	223,380	18,887,061	0.011827	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	272,781	20,386,505	0.013380	0	0	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	100,389	2,571,775	0.039035	0	0	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1,586,782	41,255,604	0.038462	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	972,291	16,346,819	0.059479	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	2,061,089	68,503,378	0.030087	0	0	73.00
74.00	07400	RENAL DIALYSIS	263,901	3,607,084	0.073162	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000	CLINIC	55,585	935,577	0.059413	0	0	90.00
90.01	09001	HOMER GLEN LAB	0	0	0.000000	0	0	90.01
90.02	09002	HOMER GLEN FEC	0	0	0.000000	0	0	90.02
90.03	09003	WOMEN'S HEALTH	0	0	0.000000	0	0	90.03
91.00	09100	EMERGENCY	3,186,559	95,143,463	0.033492	0	0	91.00
91.01	09101	OP MENTAL HEALTH	230,595	2,250,717	0.102454	0	0	91.01
91.02	09102	DIABETES CENTER	26,267	396,420	0.066261	0	0	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	9,010,502	0.000000	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
94.00	09400	HOME PROGRAM DIALYSIS	0	0	0.000000	0	0	94.00
200.00		Total (lines 50-199)	25,211,589	1,023,346,292		0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140213 Component CCN: 14T213	Period: From 10/01/2014 To 09/30/2015	Worksheet D Part IV Date/Time Prepared: 2/19/2016 2:55 am
	Title XIX	Subprovider - IRF	PPS

Cost Center Description		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	0	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	29,630	0	29,630	52.00
53.00	05300 ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	54.00
54.01	05401 ULTRASOUND	0	0	0	0	0	54.01
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 MRI	0	0	0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
60.01	06001 BLOOD LABORATORY	0	0	0	0	0	60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
65.00	06500 RESPIRATORY THERAPY	0	0	25,832	0	25,832	65.00
65.01	06501 SLEEP LAB	0	0	0	0	0	65.01
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	18,994	0	18,994	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000 CLINIC	0	0	0	0	0	90.00
90.01	09001 HOMER GLEN LAB	0	0	0	0	0	90.01
90.02	09002 HOMER GLEN FEC	0	0	0	0	0	90.02
90.03	09003 WOMEN'S HEALTH	0	0	0	0	0	90.03
91.00	09100 EMERGENCY	0	0	693,180	0	693,180	91.00
91.01	09101 OP MENTAL HEALTH	0	0	0	0	0	91.01
91.02	09102 DIABETES CENTER	0	0	0	0	0	91.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
200.00	Total (lines 50-199)	0	0	767,636	0	767,636	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140213 Component CCN: 14T213	Period: From 10/01/2014 To 09/30/2015	Worksheet D Part IV Date/Time Prepared: 2/19/2016 2:55 am
	Title XIX	Subprovider - IRF	PPS

Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
		6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0	187,941,999	0.000000	0.000000		50.00
51.00	05100 RECOVERY ROOM	0	25,434,544	0.000000	0.000000		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	29,630	9,454,293	0.003134	0.003134		52.00
53.00	05300 ANESTHESIOLOGY	0	0	0.000000	0.000000		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	154,497,494	0.000000	0.000000		54.00
54.01	05401 ULTRASOUND	0	26,145,744	0.000000	0.000000		54.01
57.00	05700 CT SCAN	0	101,077,053	0.000000	0.000000		57.00
58.00	05800 MRI	0	30,549,685	0.000000	0.000000		58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000	0.000000		59.00
60.00	06000 LABORATORY	0	170,867,058	0.000000	0.000000		60.00
60.01	06001 BLOOD LABORATORY	0	0	0.000000	0.000000		60.01
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	9,040,787	0.000000	0.000000		63.00
65.00	06500 RESPIRATORY THERAPY	25,832	17,276,975	0.001495	0.001495		65.00
65.01	06501 SLEEP LAB	0	3,143,510	0.000000	0.000000		65.01
66.00	06600 PHYSICAL THERAPY	0	8,622,245	0.000000	0.000000		66.00
67.00	06700 OCCUPATIONAL THERAPY	0	18,887,061	0.000000	0.000000		67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0.000000	0.000000		68.00
69.00	06900 ELECTROCARDIOLOGY	18,994	20,386,505	0.000932	0.000932		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	2,571,775	0.000000	0.000000		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	41,255,604	0.000000	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	16,346,819	0.000000	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	68,503,378	0.000000	0.000000		73.00
74.00	07400 RENAL DIALYSIS	0	3,607,084	0.000000	0.000000		74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	0	0.000000	0.000000		88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000		89.00
90.00	09000 CLINIC	0	935,577	0.000000	0.000000		90.00
90.01	09001 HOMER GLEN LAB	0	0	0.000000	0.000000		90.01
90.02	09002 HOMER GLEN FEC	0	0	0.000000	0.000000		90.02
90.03	09003 WOMEN'S HEALTH	0	0	0.000000	0.000000		90.03
91.00	09100 EMERGENCY	693,180	95,143,463	0.007286	0.007286		91.00
91.01	09101 OP MENTAL HEALTH	0	2,250,717	0.000000	0.000000		91.01
91.02	09102 DIABETES CENTER	0	396,420	0.000000	0.000000		91.02
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	9,010,502	0.000000	0.000000		92.00
OTHER REIMBURSABLE COST CENTERS							
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0.000000	0.000000		94.00
200.00	Total (lines 50-199)	767,636	1,023,346,292				200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140213 Component CCN: 14T213	Period: From 10/01/2014 To 09/30/2015	Worksheet D Part IV Date/Time Prepared: 2/19/2016 2:55 am
Title XIX		Subprovider - IRF	PPS

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140213	Period: From 10/01/2014 To 09/30/2015	Worksheet D Part IV Date/Time Prepared: 2/19/2016 2:55 am
	Component CCN: 14T213	Title XIX	Subprovider - IRF PPS

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

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140213	Period: From 10/01/2014 To 09/30/2015	Worksheet D-1 Date/Time Prepared: 2/19/2016 2:55 am
Cost Center Description		Title XVIII	Hospital	PPS
		1.00		
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		64,107	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		64,107	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)		56,354	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		26,985	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		65,469,217	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		65,469,217	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		65,469,217	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,021.25	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		27,558,431	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)		27,558,431	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140213		Period: From 10/01/2014 To 09/30/2015		Worksheet D-1	
Title XVIII		Hospital		PPS		Date/Time Prepared: 2/19/2016 2:55 am	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	14,423,283	6,700	2,152.73	3,262	7,022,205		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)					51,072,964		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					85,653,600		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)					5,943,612		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					5,145,171		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					11,088,783		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					74,564,817		53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges					0		54.00
55.00 Target amount per discharge					0.00		55.00
56.00 Target amount (line 54 x line 55)					0		56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0		57.00
58.00 Bonus payment (see instructions)					0		58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00		59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00		60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0		61.00
62.00 Relief payment (see instructions)					0		62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0		63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0		64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0		65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0		66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0		67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0		68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0		69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)					7,753		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,021.25		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					7,917,751		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140213		Period: From 10/01/2014 To 09/30/2015		Worksheet D-1 Date/Time Prepared: 2/19/2016 2:55 am	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	PPS
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	11,532,215	65,469,217	0.176147	7,917,751	1,394,688	90.00
91.00	Nursing School cost	0	65,469,217	0.000000	7,917,751	0	91.00
92.00	Allied health cost	0	65,469,217	0.000000	7,917,751	0	92.00
93.00	All other Medical Education	0	65,469,217	0.000000	7,917,751	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140213 Component CCN: 14S213	Period: From 10/01/2014 To 09/30/2015	Worksheet D-1 Date/Time Prepared: 2/19/2016 2:55 am
		Title XVIII	Subprovider - IPF	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		5,521	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		5,521	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		5,521	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		1,234	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		5,217,213	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		5,217,213	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		5,217,213	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)		944.98	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,166,105	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,166,105	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140213		Period: From 10/01/2014 To 09/30/2015		Worksheet D-1	
		Component CCN: 14S213				Date/Time Prepared: 2/19/2016 2:55 am	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	0	42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0	0	43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description							
					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					144,197		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,310,302		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)					229,524		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					18,039		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					247,563		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					1,062,739		53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges					0		54.00
55.00 Target amount per discharge					0.00		55.00
56.00 Target amount (line 54 x line 55)					0		56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0		57.00
58.00 Bonus payment (see instructions)					0		58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00		59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00		60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0		61.00
62.00 Relief payment (see instructions)					0		62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0		63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0		64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0		65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0		66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0		67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0		68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0		69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)					0		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140213 Component CCN: 14S213		Period: From 10/01/2014 To 09/30/2015		Worksheet D-1 Date/Time Prepared: 2/19/2016 2:55 am	
		Title XVIII		Subprovider - IPF		PPS	
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 ÷ column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	992,758	5,217,213	0.190285	0	0	90.00
91.00	Nursing School cost	0	5,217,213	0.000000	0	0	91.00
92.00	Allied health cost	34,189	5,217,213	0.006553	0	0	92.00
93.00	All other Medical Education	0	5,217,213	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140213 Component CCN: 14T213	Period: From 10/01/2014 To 09/30/2015	Worksheet D-1 Date/Time Prepared: 2/19/2016 2:55 am
		Title XVIII	Subprovider - IRF	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		7,411	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		7,411	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)		7,411	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		4,917	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)		0	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period		0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)		0	14.00
15.00	Total nursery days (title V or XIX only)		0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		9,723,106	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		9,723,106	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		9,723,106	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,311.98	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		6,451,006	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		6,451,006	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140213		Period: From 10/01/2014 To 09/30/2015		Worksheet D-1	
		Component CCN: 14T213				Date/Time Prepared: 2/19/2016 2:55 am	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0		43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					2,259,177		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					8,710,183		49.00
PASS THROUGH COST ADJUSTMENTS							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)					1,199,305		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					170,211		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					1,369,516		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					7,340,667		53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges					0		54.00
55.00 Target amount per discharge					0.00		55.00
56.00 Target amount (line 54 x line 55)					0		56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0		57.00
58.00 Bonus payment (see instructions)					0		58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00		59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00		60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0		61.00
62.00 Relief payment (see instructions)					0		62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0		63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0		64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0		65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0		66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0		67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0		68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0		69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)					0		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140213 Component CCN: 14T213		Period: From 10/01/2014 To 09/30/2015		Worksheet D-1 Date/Time Prepared: 2/19/2016 2:55 am	
		Title XVIII		Subprovider - IRF		PPS	
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,807,626	9,723,106	0.185910	0	0	90.00
91.00	Nursing School cost	0	9,723,106	0.000000	0	0	91.00
92.00	Allied health cost	0	9,723,106	0.000000	0	0	92.00
93.00	All other Medical Education	0	9,723,106	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140213	Period: From 10/01/2014 To 09/30/2015	Worksheet D-1 Date/Time Prepared: 2/19/2016 2:55 am
		Title XIX	Hospital	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		64,107	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		64,107	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)		56,354	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)		6,948	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)		6,735	15.00
16.00	Nursery days (title V or XIX only)		970	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		65,469,217	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		65,469,217	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		65,469,217	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,021.25	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		7,095,645	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)		7,095,645	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140213		Period: From 10/01/2014 To 09/30/2015		Worksheet D-1	
Title XIX		Hospital		PPS		Date/Time Prepared: 2/19/2016 2:55 am	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
42.00 NURSERY (title V & XIX only)	9,175,974	6,735	1,362.43	970	1,321,557		42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	14,423,283	6,700	2,152.73	965	2,077,384		43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description							
					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						0	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						10,494,586	49.00
PASS THROUGH COST ADJUSTMENTS							
50.00 Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and III)						2,039,338	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						0	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)						2,039,338	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						8,455,248	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges						0	54.00
55.00 Target amount per discharge						0.00	55.00
56.00 Target amount (line 54 x line 55)						0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0	57.00
58.00 Bonus payment (see instructions)						0	58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						0.00	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						0	61.00
62.00 Relief payment (see instructions)						0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)						0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						0	66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)						7,753	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						1,021.25	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)						7,917,751	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140213		Period: From 10/01/2014 To 09/30/2015		Worksheet D-1 Date/Time Prepared: 2/19/2016 2:55 am	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	11,532,215	65,469,217	0.176147	7,917,751	1,394,688	90.00
91.00	Nursing School cost	0	65,469,217	0.000000	7,917,751	0	91.00
92.00	Allied health cost	0	65,469,217	0.000000	7,917,751	0	92.00
93.00	All other Medical Education	0	65,469,217	0.000000	7,917,751	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140213	Period: From 10/01/2014 To 09/30/2015	Worksheet D-1
		Component CCN: 14S213		Date/Time Prepared: 2/19/2016 2:55 am
		Title XIX	Subprovider - IPF	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		5,521	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		5,521	2.00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.		0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		5,521	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period		0	5.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	6.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period		0	7.00
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		0	8.00
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)		1,174	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)		6,735	15.00
16.00	Nursery days (title V or XIX only)		970	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		5,217,213	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		5,217,213	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		5,217,213	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)		944.98	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		1,109,407	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)		0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)		1,109,407	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140213		Period: From 10/01/2014 To 09/30/2015		Worksheet D-1	
		Component CCN: 14S213				Date/Time Prepared: 2/19/2016 2:55 am	
		Title XIX		Subprovider - IPF		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)		
	1.00	2.00	3.00	4.00	5.00		
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0		42.00
Intensive Care Type Inpatient Hospital Units							
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0		43.00
44.00 CORONARY CARE UNIT							44.00
45.00 BURN INTENSIVE CARE UNIT							45.00
46.00 SURGICAL INTENSIVE CARE UNIT							46.00
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00
Cost Center Description					1.00		
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)					0		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					1,109,407		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)					218,364		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					0		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					218,364		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					891,043		53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00 Program discharges					0		54.00
55.00 Target amount per discharge					0.00		55.00
56.00 Target amount (line 54 x line 55)					0		56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0		57.00
58.00 Bonus payment (see instructions)					0		58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00		59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00		60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0		61.00
62.00 Relief payment (see instructions)					0		62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0		63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0		64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0		65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0		66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0		67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0		68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0		69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY							
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)							70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)							71.00
72.00 Program routine service cost (line 9 x line 71)							72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)							73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)							74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)							75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)							76.00
77.00 Program capital-related costs (line 9 x line 76)							77.00
78.00 Inpatient routine service cost (line 74 minus line 77)							78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)							79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)							80.00
81.00 Inpatient routine service cost per diem limitation							81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)							82.00
83.00 Reasonable inpatient routine service costs (see instructions)							83.00
84.00 Program inpatient ancillary services (see instructions)							84.00
85.00 Utilization review - physician compensation (see instructions)							85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)							86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00 Total observation bed days (see instructions)					0		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					0.00		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					0		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140213 Component CCN: 14S213		Period: From 10/01/2014 To 09/30/2015		Worksheet D-1 Date/Time Prepared: 2/19/2016 2:55 am	
		Title XIX		Subprovider - IPF		PPS	
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	992,758	5,217,213	0.190285	0	0	90.00
91.00	Nursing School cost	0	5,217,213	0.000000	0	0	91.00
92.00	Allied health cost	34,189	5,217,213	0.006553	0	0	92.00
93.00	All other Medical Education	0	5,217,213	0.000000	0	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140213 Component CCN: 14T213	Period: From 10/01/2014 To 09/30/2015	Worksheet D-1 Date/Time Prepared: 2/19/2016 2:55 am
		Title XIX	Subprovider - IRF	PPS
Cost Center Description				1.00
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		7,411	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		7,411	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)		7,411	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)		178	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)		6,735	15.00
16.00	Nursery days (title V or XIX only)		970	16.00
SWING BED ADJUSTMENT				
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		0.00	17.00
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		0.00	18.00
19.00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period		0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period		0.00	20.00
21.00	Total general inpatient routine service cost (see instructions)		9,723,106	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)		0	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)		0	23.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)		0	24.00
25.00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)		0	25.00
26.00	Total swing-bed cost (see instructions)		0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		9,723,106	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)		0	28.00
29.00	Private room charges (excluding swing-bed charges)		0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		0.00	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		0.00	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		0.00	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		9,723,106	37.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY				
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38.00	Adjusted general inpatient routine service cost per diem (see instructions)		1,311.98	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		233,532	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)		233,532	41.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140213		Period: From 10/01/2014 To 09/30/2015		Worksheet D-1		
		Component CCN: 14T213				Date/Time Prepared: 2/19/2016 2:55 am		
		Title XIX		Subprovider - IRF		PPS		
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)			
	1.00	2.00	3.00	4.00	5.00			
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0		42.00	
Intensive Care Type Inpatient Hospital Units								
43.00 INTENSIVE CARE UNIT	0	0	0.00	0	0		43.00	
44.00 CORONARY CARE UNIT							44.00	
45.00 BURN INTENSIVE CARE UNIT							45.00	
46.00 SURGICAL INTENSIVE CARE UNIT							46.00	
47.00 OTHER SPECIAL CARE (SPECIFY)							47.00	
Cost Center Description					1.00			
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)						0		48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						233,532		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)						43,416		50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)						0		51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)						43,416		52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)						190,116		53.00
TARGET AMOUNT AND LIMIT COMPUTATION								
54.00 Program discharges						0		54.00
55.00 Target amount per discharge						0.00		55.00
56.00 Target amount (line 54 x line 55)						0		56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)						0		57.00
58.00 Bonus payment (see instructions)						0		58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						0.00		59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						0.00		60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)						0		61.00
62.00 Relief payment (see instructions)						0		62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)						0		63.00
PROGRAM INPATIENT ROUTINE SWING BED COST								
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)						0		64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						0		65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)						0		66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)						0		67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						0		68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)						0		69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY								
70.00 Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)								70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)								71.00
72.00 Program routine service cost (line 9 x line 71)								72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)								73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)								74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)								75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)								76.00
77.00 Program capital-related costs (line 9 x line 76)								77.00
78.00 Inpatient routine service cost (line 74 minus line 77)								78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)								79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)								80.00
81.00 Inpatient routine service cost per diem limitation								81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)								82.00
83.00 Reasonable inpatient routine service costs (see instructions)								83.00
84.00 Program inpatient ancillary services (see instructions)								84.00
85.00 Utilization review - physician compensation (see instructions)								85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)								86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST								
87.00 Total observation bed days (see instructions)						0		87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)						0.00		88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)						0		89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140213 Component CCN: 14T213		Period: From 10/01/2014 To 09/30/2015		Worksheet D-1 Date/Time Prepared: 2/19/2016 2:55 am	
		Title XIX		Subprovider - IRF		PPS	
Cost Center Description	Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	1,807,626	9,723,106	0.185910	0	0	90.00
91.00	Nursing School cost	0	9,723,106	0.000000	0	0	91.00
92.00	Allied health cost	0	9,723,106	0.000000	0	0	92.00
93.00	All other Medical Education	0	9,723,106	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140213	Period: From 10/01/2014 To 09/30/2015	Worksheet D-3 Date/Time Prepared: 2/19/2016 2:55 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		31,175,594	30.00
31.00	03100	INTENSIVE CARE UNIT		8,922,414	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.187515	21,705,488	4,070,105 50.00
51.00	05100	RECOVERY ROOM	0.103628	3,857,394	399,734 51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.717606	14,345	10,294 52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	0 53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.182766	18,596,034	3,398,723 54.00
54.01	05401	ULTRASOUND	0.101627	3,954,716	401,906 54.01
57.00	05700	CT SCAN	0.037866	16,564,082	627,216 57.00
58.00	05800	MRI	0.076218	4,555,953	347,246 58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	0 59.00
60.00	06000	LABORATORY	0.075249	33,331,106	2,508,132 60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	0 60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.270761	2,783,786	753,741 63.00
65.00	06500	RESPIRATORY THERAPY	0.180083	10,629,051	1,914,111 65.00
65.01	06501	SLEEP LAB	0.167236	0	0 65.01
66.00	06600	PHYSICAL THERAPY	0.329019	3,384,049	1,113,416 66.00
67.00	06700	OCCUPATIONAL THERAPY	0.235077	1,743,061	409,754 67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	0 68.00
69.00	06900	ELECTROCARDIOLOGY	0.115530	6,925,748	800,132 69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.246512	365,941	90,209 70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.470251	15,671,664	7,369,616 71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.302519	12,198,004	15,888,132 72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.331115	20,221,267	6,695,565 73.00
74.00	07400	RENAL DIALYSIS	0.346214	2,324,833	804,890 74.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		0 88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0 89.00
90.00	09000	CLINIC	1.164342	1,061	1,235 90.00
90.01	09001	HOMER GLEN LAB	0.000000	0	0 90.01
90.02	09002	HOMER GLEN FEC	0.000000	0	0 90.02
90.03	09003	WOMEN'S HEALTH	0.000000	0	0 90.03
91.00	09100	EMERGENCY	0.200868	13,500,815	2,711,882 91.00
91.01	09101	OP MENTAL HEALTH	0.481882	0	0 91.01
91.02	09102	DIABETES CENTER	1.171058	18,106	21,203 91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.878725	837,261	735,722 92.00
OTHER REIMBURSABLE COST CENTERS					
94.00	09400	HOME PROGRAM DIALYSIS	0.000000	0	0 94.00
200.00		Total (sum of lines 50-94 and 96-98)		193,183,765	51,072,964 200.00
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)		193,183,765	51,072,964 202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140213	Period: From 10/01/2014 To 09/30/2015	Worksheet D-3	
		Component CCN: 14S213		Date/Time Prepared: 2/19/2016 2:55 am	
		Title XVIIII	Subprovider - IPF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
40.00	04000	SUBPROVIDER - IPF		1,385,894	40.00
41.00	04100	SUBPROVIDER - IRF		0	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.187515	19,484	50.00
51.00	05100	RECOVERY ROOM	0.103628	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.717606	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.182766	17,145	54.00
54.01	05401	ULTRASOUND	0.101627	8,506	54.01
57.00	05700	CT SCAN	0.037866	21,312	57.00
58.00	05800	MRI	0.076218	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.075249	281,020	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.270761	7,614	63.00
65.00	06500	RESPIRATORY THERAPY	0.180083	23,900	65.00
65.01	06501	SLEEP LAB	0.167236	0	65.01
66.00	06600	PHYSICAL THERAPY	0.329019	10,160	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.235077	3,825	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.115530	13,940	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.246512	625	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.470251	867	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.302519	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.331115	174,223	73.00
74.00	07400	RENAL DIALYSIS	0.346214	3,261	74.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	89.00
90.00	09000	CLINIC	1.164342	0	90.00
90.01	09001	HOMER GLEN LAB	0.000000	0	90.01
90.02	09002	HOMER GLEN FEC	0.000000	0	90.02
90.03	09003	WOMEN'S HEALTH	0.000000	0	90.03
91.00	09100	EMERGENCY	0.200868	207,082	91.00
91.01	09101	OP MENTAL HEALTH	0.481882	0	91.01
91.02	09102	DIABETES CENTER	1.171058	1,195	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.878725	0	92.00
OTHER REIMBURSABLE COST CENTERS					
94.00	09400	HOME PROGRAM DIALYSIS	0.000000	0	94.00
200.00		Total (sum of lines 50-94 and 96-98)		794,159	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net Charges (line 200 minus line 201)		794,159	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140213	Period: From 10/01/2014 To 09/30/2015	Worksheet D-3	
		Component CCN: 14T213		Date/Time Prepared: 2/19/2016 2:55 am	
		Title XVIII	Subprovider - IRF	PPS	
Cost Center Description		Ratio of Cost To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS		0	30.00
31.00	03100	INTENSIVE CARE UNIT		0	31.00
40.00	04000	SUBPROVIDER - IPF		0	40.00
41.00	04100	SUBPROVIDER - IRF		5,111,701	41.00
42.00	04200	SUBPROVIDER		0	42.00
43.00	04300	NURSERY			43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.187515	200,654	50.00
51.00	05100	RECOVERY ROOM	0.103628	14,923	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.717606	0	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.182766	222,581	54.00
54.01	05401	ULTRASOUND	0.101627	97,853	54.01
57.00	05700	CT SCAN	0.037866	169,661	57.00
58.00	05800	MRI	0.076218	86,293	58.00
59.00	05900	CARDIAC CATHETERIZATION	0.000000	0	59.00
60.00	06000	LABORATORY	0.075249	1,002,627	60.00
60.01	06001	BLOOD LABORATORY	0.000000	0	60.01
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0.270761	82,625	63.00
65.00	06500	RESPIRATORY THERAPY	0.180083	560,713	65.00
65.01	06501	SLEEP LAB	0.167236	0	65.01
66.00	06600	PHYSICAL THERAPY	0.329019	2,577,591	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.235077	2,387,925	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.115530	49,728	69.00
70.00	07000	ELECTROENCEPHALOGRAPHY	0.246512	14,358	70.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.470251	283,012	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.302519	22,266	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.331115	1,024,593	73.00
74.00	07400	RENAL DIALYSIS	0.346214	102,698	74.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0.000000		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0.000000		89.00
90.00	09000	CLINIC	1.164342	0	90.00
90.01	09001	HOMER GLEN LAB	0.000000	0	90.01
90.02	09002	HOMER GLEN FEC	0.000000	0	90.02
90.03	09003	WOMEN'S HEALTH	0.000000	0	90.03
91.00	09100	EMERGENCY	0.200868	195	91.00
91.01	09101	OP MENTAL HEALTH	0.481882	0	91.01
91.02	09102	DIABETES CENTER	1.171058	1,655	91.02
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.878725	0	92.00
OTHER REIMBURSABLE COST CENTERS					
94.00	09400	HOME PROGRAM DIALYSIS	0.000000	0	94.00
200.00		Total (sum of lines 50-94 and 96-98)		8,901,951	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net Charges (line 200 minus line 201)		8,901,951	202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140213	Period: From 10/01/2014 To 09/30/2015	Worksheet E Part A Date/Time Prepared: 2/19/2016 2:55 am	
		Title XVIII	Hospital		PPS
		0	before 1/1	on/after 1/1	2.00
PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS					
1.00	DRG Amounts Other than Outlier Payments		0		1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		0		1.01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		56,087,591		1.02
1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)		0		1.03
1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)		0		1.04
2.00	Outlier payments for discharges. (see instructions)		518,728		2.00
2.01	Outlier reconciliation amount		0		2.01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0		2.02
3.00	Managed Care Simulated Payments		8,038,083		3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		229.76		4.00
Indirect Medical Education Adjustment					
5.00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996. (see instructions)		0.00		5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00		6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00		7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00		7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00		8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00		8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00		8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		0.00		9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00		10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00		11.00
12.00	Current year allowable FTE (see instructions)		0.00		12.00
13.00	Total allowable FTE count for the prior year.		0.00		13.00
14.00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.		0.00		14.00
15.00	Sum of lines 12 through 14 divided by 3.		0.00		15.00
16.00	Adjustment for residents in initial years of the program		0.00		16.00
17.00	Adjustment for residents displaced by program or hospital closure		0.00		17.00
18.00	Adjusted rolling average FTE count		0.00		18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.000000		19.00
20.00	Prior year resident to bed ratio (see instructions)		0.000000		20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.000000		21.00
22.00	IME payment adjustment (see instructions)		0		22.00
22.01	IME payment adjustment - Managed Care (see instructions)		0		22.01
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA					
23.00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C).		0.00		23.00
24.00	IME FTE Resident Count Over Cap (see instructions)		0.00		24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00		25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000		26.00
27.00	IME payments adjustment factor. (see instructions)		0.000000		27.00
28.00	IME add-on adjustment amount (see instructions)		0		28.00
28.01	IME add-on adjustment amount - Managed Care (see instructions)		0		28.01
29.00	Total IME payment (sum of lines 22 and 28)		0		29.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140213	Period: From 10/01/2014 To 09/30/2015	Worksheet E Part A Date/Time Prepared: 2/19/2016 2:55 am	
		Title XVIII	Hospital		PPS
		0	before 1/1	on/after 1/1	2.00
29.01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)		1.00	1.01	29.01
Disproportionate Share Adjustment					
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		2.66		30.00
31.00	Percentage of Medicaid patient days (see instructions)		14.40		31.00
32.00	Sum of lines 30 and 31		17.06		32.00
33.00	Allowable disproportionate share percentage (see instructions)		3.84		33.00
34.00	Disproportionate share adjustment (see instructions)		538,441		34.00
			Prior to October 1	On/After October 1	
		0	1.00	1.01	2.00
Uncompensated Care Adjustment					
35.00	Total uncompensated care amount (see instructions)		0		35.00
35.01	Factor 3 (see instructions)		0.000000000	0.000267154	35.01
35.02	Hospital uncompensated care payment (if line 34 is zero, enter zero on this line) (see instructions)		0	2,043,096	35.02
35.03	Pro rata share of the hospital uncompensated care payment amount (see instructions)		0	2,043,096	35.03
36.00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		2,043,096		36.00
Additional payment for high percentage of ESRD beneficiary discharges (lines 40 through 46)					
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0		40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0	41.00
41.01	Total ESRD Medicare covered and paid discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	0	41.01
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00		42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0		43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000		44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41.01)		0		46.00
47.00	Subtotal (see instructions)		59,187,856		47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0		48.00
49.00	Total payment for inpatient operating costs (see instructions)		59,187,856		49.00
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		4,836,707		50.00
51.00	Exception payment for inpatient program capital (Wkst. L, Pt. III, see instructions)		0		51.00
52.00	Direct graduate medical education payment (from Wkst. E-4, line 49 see instructions).		0		52.00
53.00	Nursing and Allied Health Managed Care payment		29,089		53.00
54.00	Special add-on payments for new technologies		1,705		54.00
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)		0		55.00
56.00	Cost of physicians' services in a teaching hospital (see instructions)		0		56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).		23,291		57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		120,757		58.00
59.00	Total (sum of amounts on lines 49 through 58)		64,199,405		59.00
60.00	Primary payer payments		10,787		60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		64,188,618		61.00
62.00	Deductibles billed to program beneficiaries		6,411,724		62.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140213	Period: From 10/01/2014 To 09/30/2015	Worksheet E Part A Date/Time Prepared: 2/19/2016 2:55 am	
		Title XVIII	Hospital	PPS	
		0	Prior to October 1 1.00	1.01	On/After October 1 2.00
63.00	Coinsurance billed to program beneficiaries		194,100		63.00
64.00	Allowable bad debts (see instructions)		879,477		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		571,660		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		492,801		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		58,154,454		67.00
68.00	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0		68.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0		69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		70.00
70.50	RURAL DEMONSTRATION PROJECT		0		70.50
70.89	Pioneer ACO demonstration payment adjustment amount (see instructions)		0		70.89
70.90	HSP bonus payment HVBP adjustment amount (see instructions)		0		70.90
70.91	HSP bonus payment HRR adjustment amount (see instructions)		0		70.91
70.92	Bundled Model 1 discount amount (see instructions)		0		70.92
70.93	HVBP payment adjustment amount (see instructions)		-7,778		70.93
70.94	HRR adjustment amount (see instructions)		-807,687		70.94
70.95	Recovery of accelerated depreciation		0		70.95
70.96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)	0	0		70.96
70.97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0		70.97
70.98	Low Volume Payment-3		0		70.98
70.99	HAC adjustment amount (see instructions)		0		70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		57,338,989		71.00
71.01	Sequestration adjustment (see instructions)		1,146,780		71.01
72.00	Interim payments		56,552,484		72.00
73.00	Tentative settlement (for contractor use only)		0		73.00
74.00	Balance due provider (Program) (line 71 minus lines 71.01, 72, and 73)		-360,275		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		1,111,358		75.00
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0		90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0		91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0		92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0		93.00
94.00	The rate used to calculate the time value of money (see instructions)		0.00		94.00
95.00	Time value of money for operating expenses (see instructions)		0		95.00
96.00	Time value of money for capital related expenses (see instructions)		0		96.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140213	Period: From 10/01/2014 To 09/30/2015	Worksheet E Part A Date/Time Prepared: 2/19/2016 2:55 am
		Title XVIII	Hospital	PPS
		Prior to 10/1		On/After 10/1
	HSP Bonus Payment Amount	1.00	1.01	2.00
100.00	HSP bonus amount (see instructions)			0
	HVBP Adjustment for HSP Bonus Payment			
101.00	HVBP adjustment factor (see instructions)			0
102.00	HVBP adjustment amount for HSP bonus payment (see instructions)			0
	HRR Adjustment for HSP Bonus Payment			
103.00	HRR adjustment factor (see instructions)			0.0000
104.00	HRR adjustment amount for HSP bonus payment (see instructions)			0

CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 140213		Period: From 10/01/2014 To 09/30/2015		Worksheet DSH	
		Title XVIII		Hospital		Date/Time Prepared: 2/19/2016 2:55 am	
		PPS					
		Original .mcrcx Values	Adjusted .mcax Values	HFS Look Up	Override Value	Revised Value	
		1.00	2.00	3.00	4.00	5.00	
CALCULATION OF THE DSH PAYMENT PERCENTAGE							
1.00	Percentage of SSI patient days to Medicare Part A days (Previous from E, Part A, line 30 - Revised from CMS)	2.66	0.00	0.00	0.00	0.00	1.00
2.00	Percentage of Medicaid patient days to total days (From line 27)	14.40	0.00			14.40	2.00
3.00	Sum of lines 1 and 2, if less than 15% DSH Payment Percentage = 0	17.06	0.00			14.40	3.00
4.00	Provider Type * (urban, rural, SCH, RRC, pickle - If pickle worksheet NA)	Urban				Urban	4.00
5.00	Bed days available divided by number of days in the cost reporting period (Worksheet E, Part A, Line 4)	229.76	0.00			229.76	5.00
6.00	Disproportionate Share Payment Percentage (transferred from Worksheet E, Part A, line 33)	3.84	0.00			0.00	6.00
7.00	Qualify for Operating DSH Eligibility (DPP 15% or more)?	Yes				No	7.00
8.00	S-2, Line 22	Yes				Yes	8.00
9.00	Qualify for Capital DSH Eligibility (Urban with 100 or more beds)?	Yes				No	9.00
10.00	S-2, Line 45	Yes				Yes	10.00
11.00	Is the provider reimbursed under the fully prospective method? (Worksheet L, Part I, line 1 greater than -0-)	Yes				Yes	11.00
12.00	Percentage of SSI patient days to Medicare Part A days (Previous from L, Part I, line 7 - Revised from CMS)	2.66	0.00	0.00	0.00	0.00	12.00
13.00	Is this an IRF provider or a provider with an IRF excluded unit (Worksheet S-2, line 75, column 1 = "Y")	Yes				Yes	13.00
14.00	Medicare SSI ratio (Previous from E-3, Part III, line 2 - Revised from CMS)	2.00	0.00	0.00	0.00	0.00	14.00
CALCULATION OF THE PERCENTAGE OF MEDICAID DAYS TO TOTAL DAYS							
15.00	In-State Medicaid paid days (Worksheet S-2, line 24, column 1)	5,947	0			5,947	15.00
16.00	In-State Medicaid eligible unpaid paid days (Worksheet S-2, line 24, column 2)	3,158	0			3,158	16.00
17.00	Out-of-State Medicaid paid days (Worksheet S-2, line 24, column 3)	0	0			0	17.00
18.00	Out-of-State Medicaid eligible unpaid days (Worksheet S-2, line 24, column 4)	0	0			0	18.00
18.01	N/A	0	0			0	18.01
19.00	Medicaid HMO days (Worksheet S-2, line 24, column 5)	1,166	0			1,166	19.00
20.00	Other Medicaid days (Worksheet S-2, line 24, column 6)	0	0			0	20.00
21.00	Total Medicaid patient days for the DSH calculation (sum of lines 15-20)	10,271	0			10,271	21.00
22.00	Total patient days (Worksheet S-3, Part I, Column 8, Line 14)	69,789	0			69,789	22.00
23.00	Plus total labor room days (Worksheet S-3, Part I, Column 8, Line 32)	1,548	0			1,548	23.00
24.00	Plus total employee discount days (Worksheet S-3, Part I, Column 8, Line 30)	0	0			0	24.00
25.00	Less total Swing-bed SNF and NF patient days (Worksheet S-3, Part I, Column 8, Lines 5 and 6)	0	0			0	25.00
26.00	Total Medicaid patient days for the DSH calculation (sum of lines 22-24, less line 25)	71,337	0			71,337	26.00
27.00	Percentage of Medicaid patient days to total days (Line 21 divided by line 26)	14.40	0.00			14.40	27.00

CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 140213		Period: From 10/01/2014 To 09/30/2015		Worksheet DSH Date/Time Prepared: 2/19/2016 2:55 am	
		Title XVIII		Hospital		PPS	
		Original .mcrx Values		Adjusted .mcax Values		Revised	
		Condition	Percentage	Condition	Percentage	Condition	
		1.00	2.00	3.00	4.00	5.00	
CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE							
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	False	0.00		0.00	False	28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	True	3.84		0.00	True	29.00
30.00	Line 28 or 29 as applicable		3.84		0.00		30.00
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.		0.00		0.00		31.00
		Original .mcrx Values	Adjusted .mcax Values	HFS Look Up	Override Value	Revised Value	
		1.00	2.00	3.00	4.00	5.00	
DETERMINATION OF PROVIDER TYPE							
32.00	Does the hospital qualify under the Pickle amendment? (Worksheet S-2, Part I, Line 22, column 2 = "Y")	False				False	32.00
33.00	Is This a Rural Referral Center? (Worksheet S-2, Part I, line 116, column 1 = "Y")	False				False	33.00
34.00	Is this a Medicare Dependant Hospital? (Worksheet S-2, Part I, Line 37 greater than -0-)	False				False	34.00
35.00	Is this a Sole Community hospital? (Worksheet S-2, Part I, Line 35 greater than -0-)	False				False	35.00
36.00	Is this an Urban or Rural hospital? (Worksheet S-2, Part I, Line 26, Column 1, Urban=1, Rural=2)	Urban				Urban	36.00

CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 140213	Period: From 10/01/2014 To 09/30/2015	Worksheet DSH Date/Time Prepared: 2/19/2016 2:55 am
		Title XVIII	Hospital	PPS

		Revised		
		Percentage		
		6.00		
CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE				
28.00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	0.00		28.00
29.00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	2.89		29.00
30.00	Line 28 or 29 as applicable	2.89		30.00
31.00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.	0.00		31.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140213	Period: From 10/01/2014 To 09/30/2015	Worksheet E Part B Date/Time Prepared: 2/19/2016 2:55 am
		Title XVII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		84,634	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		29,931,919	2.00
3.00	PPS payments		22,526,838	3.00
4.00	Outlier payment (see instructions)		89,548	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		71,053	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		84,634	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		111,777	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		111,777	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)		111,777	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		27,143	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)		84,634	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of physicians' services in a teaching hospital (see instructions)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)		22,687,439	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		10,344	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		4,692,330	26.00
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see instructions)		18,069,399	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		18,069,399	30.00
31.00	Primary payer payments		2,119	31.00
32.00	Subtotal (line 30 minus line 31)		18,067,280	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		473,714	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		307,914	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		272,494	36.00
37.00	Subtotal (see instructions)		18,375,194	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	39.50
39.98	Partial or full credits received from manufacturers for replaced devices (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (see instructions)		18,375,194	40.00
40.01	Sequestration adjustment (see instructions)		367,504	40.01
41.00	Interim payments		18,038,736	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (see instructions)		-31,046	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		386,722	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
			Overrides	
			1.00	
WORKSHEET OVERRIDE VALUES				
112.00	Override of Ancillary service charges (line 12)			0.112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140213

Period:
From 10/01/2014
To 09/30/2015

Worksheet E-1
Part I
Date/Time Prepared:
2/19/2016 2:55 am

		Title XVIII		Hospital		PPS	
		Inpatient Part A		Part B			
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount		
		1.00	2.00	3.00	4.00		
1.00	Total interim payments paid to provider		56,600,137		18,168,495	1.00	
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00	
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						3.00
Program to Provider							
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01	
3.02			0		0	3.02	
3.03			0		0	3.03	
3.04			0		0	3.04	
3.05			0		0	3.05	
Provider to Program							
3.50	ADJUSTMENTS TO PROGRAM	04/21/2015	47,653	04/21/2015	129,759	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)		-47,653		-129,759	3.99	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		56,552,484		18,038,736	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						5.00
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)						6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01	
6.02	SETTLEMENT TO PROGRAM		360,275		31,046	6.02	
7.00	Total Medicare program liability (see instructions)		56,192,209		18,007,690	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: 140213
Component CCN: 14S213

Period:
From 10/01/2014
To 09/30/2015

Worksheet E-1
Part I
Date/Time Prepared:
2/19/2016 2:55 am

Title XVIII

Subprovider -
IPF

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		934,813		0	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER		0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		934,813		0	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01	TENTATIVE TO PROVIDER		0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50	TENTATIVE TO PROGRAM		0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		50,365		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		985,178		0	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					8.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140213
Component CCN: 14T213

Period:
From 10/01/2014
To 09/30/2015

Worksheet E-1
Part I
Date/Time Prepared:
2/19/2016 2:55 am

Title XVIII

Subprovider -
IRF

PPS

		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider					0 1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		7,680,907			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)					0 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)		7,680,907			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)					0 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)					0 6.00
6.01	SETTLEMENT TO PROVIDER		46,889			0 6.01
6.02	SETTLEMENT TO PROGRAM		0			0 6.02
7.00	Total Medicare program liability (see instructions)		7,727,796			0 7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
			0	1.00	2.00	
8.00	Name of Contractor					0 8.00

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 140213	Period: From 10/01/2014 To 09/30/2015	Worksheet E-1 Part II Date/Time Prepared: 2/19/2016 2:55 am
		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14		18,679	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12		30,247	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2		4,504	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12		63,054	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200		1,136,099,992	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 line 20		14,664,256	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168		0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)		1,537,000	8.00
9.00	Sequestration adjustment amount (see instructions)		30,740	9.00
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)		1,506,260	10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)		0	30.00
31.00	Other Adjustment (specify)		0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)		1,506,260	32.00
		Overrides		
		1.00		
CONTRACTOR OVERRIDES				
108.00	Override of HIT payment			0108.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140213	Period: From 10/01/2014 To 09/30/2015	Worksheet E-3 Part II Date/Time Prepared: 2/19/2016 2:55 am
		Component CCN: 14S213	Title XVII	Subprovider - IPF PPS
				1.00
PART II - MEDICARE PART A SERVICES - IPF PPS				
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)		1,064,873	1.00
2.00	Net IPF PPS Outlier Payments		2,844	2.00
3.00	Net IPF PPS ECT Payments		0	3.00
4.00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see instructions)		0.00	4.00
4.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)		0.00	4.01
5.00	New Teaching program adjustment. (see instructions)		0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)		0.00	6.00
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)		0.00	7.00
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)		0.00	8.00
9.00	Average Daily Census (see instructions)		15.126027	9.00
10.00	Teaching Adjustment Factor $\{((1 + (\text{line 8}/\text{line 9})) \text{ raised to the power of } .5150 - 1)\}$.		0.000000	10.00
11.00	Teaching Adjustment (line 1 multiplied by line 10).		0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)		1,067,717	12.00
13.00	Nursing and Allied Health Managed Care payment (see instruction)		0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)			14.00
15.00	Cost of physicians' services in a teaching hospital (see instructions)		0	15.00
16.00	Subtotal (see instructions)		1,067,717	16.00
17.00	Primary payer payments		0	17.00
18.00	Subtotal (line 16 less line 17).		1,067,717	18.00
19.00	Deductibles		105,004	19.00
20.00	Subtotal (line 18 minus line 19)		962,713	20.00
21.00	Coinsurance		8,820	21.00
22.00	Subtotal (line 20 minus line 21)		953,893	22.00
23.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		64,916	23.00
24.00	Adjusted reimbursable bad debts (see instructions)		42,195	24.00
25.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		46,197	25.00
26.00	Subtotal (sum of lines 22 and 24)		996,088	26.00
27.00	Direct graduate medical education payments (from Wkst. E-4, line 49)		0	27.00
28.00	Other pass through costs (see instructions)		9,196	28.00
29.00	Outlier payments reconciliation		0	29.00
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	30.00
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	30.50
30.99	Recovery of Accelerated Depreciation		0	30.99
31.00	Total amount payable to the provider (see instructions)		1,005,284	31.00
31.01	Sequestration adjustment (see instructions)		20,106	31.01
32.00	Interim payments		934,813	32.00
33.00	Tentative settlement (for contractor use only)		0	33.00
34.00	Balance due provider/program (line 31 minus lines 31.01, 32 and 33)		50,365	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		4,504	35.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Worksheet E-3, Part II, line 2		2,844	50.00
51.00	Outlier reconciliation adjustment amount (see instructions)		0	51.00
52.00	The rate used to calculate the Time Value of Money		0.00	52.00
53.00	Time Value of Money (see instructions)		0	53.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140213 Component CCN: 14T213	Period: From 10/01/2014 To 09/30/2015	Worksheet E-3 Part III Date/Time Prepared: 2/19/2016 2:55 am
		Title XVII	Subprovider - IRF	PPS
				1.00
PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)			7,315,422 1.00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0200 2.00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			113,389 3.00
4.00	Outlier Payments			503,293 4.00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)			0.00 5.00
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)			0.00 5.01
6.00	New Teaching program adjustment. (see instructions)			0.00 6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)			0.00 7.00
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)			0.00 8.00
9.00	Intern and resident count for IRF PPS medical education adjustment (see instructions)			0.00 9.00
10.00	Average Daily Census (see instructions)			20.304110 10.00
11.00	Teaching Adjustment Factor (see instructions)			0.000000 11.00
12.00	Teaching Adjustment (see instructions)			0 12.00
13.00	Total PPS Payment (see instructions)			7,932,104 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)			0 15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)			0 16.00
17.00	Subtotal (see instructions)			7,932,104 17.00
18.00	Primary payer payments			0 18.00
19.00	Subtotal (line 17 less line 18).			7,932,104 19.00
20.00	Deductibles			35,060 20.00
21.00	Subtotal (line 19 minus line 20)			7,897,044 21.00
22.00	Coinsurance			14,175 22.00
23.00	Subtotal (line 21 minus line 22)			7,882,869 23.00
24.00	Allowable bad debts (exclude bad debts for professional services) (see instructions)			2,696 24.00
25.00	Adjusted reimbursable bad debts (see instructions)			1,752 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)			7,884,621 27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 49)			0 28.00
29.00	Other pass through costs (see instructions)			885 29.00
30.00	Outlier payments reconciliation			0 30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0 31.00
31.50	Pioneer ACO demonstration payment adjustment (see instructions)			0 31.50
31.99	Recovery of Accelerated Depreciation			0 31.99
32.00	Total amount payable to the provider (see instructions)			7,885,506 32.00
32.01	Sequestration adjustment (see instructions)			157,710 32.01
33.00	Interim payments			7,680,907 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)			46,889 35.00
36.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0 36.00
TO BE COMPLETED BY CONTRACTOR				
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4			503,293 50.00
51.00	Outlier reconciliation adjustment amount (see instructions)			0 51.00
52.00	The rate used to calculate the Time Value of Money			0.00 52.00
53.00	Time Value of Money (see instructions)			0 53.00

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

Provider CCN: 140213

Period:
From 10/01/2014
To 09/30/2015

Worksheet G

Date/Time Prepared:
2/19/2016 2:55 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	28,081,000	0	0	0	1.00
2.00	Temporary investments	2,348,000	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	44,026,000	0	0	0	4.00
5.00	Other receivable	765,000	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	0	0	0	0	7.00
8.00	Prepaid expenses	4,645,000	0	0	0	8.00
9.00	Other current assets	371,000	0	0	0	9.00
10.00	Due from other funds	38,773,000	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	119,009,000	0	0	0	11.00
FIXED ASSETS						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	585,533,913	0	0	0	15.00
16.00	Accumulated depreciation	-162,406,913	0	0	0	16.00
17.00	Leasehold improvements	0	0	0	0	17.00
18.00	Accumulated depreciation	0	0	0	0	18.00
19.00	Fixed equipment	0	0	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	0	0	0	0	21.00
22.00	Accumulated depreciation	0	0	0	0	22.00
23.00	Major movable equipment	0	0	0	0	23.00
24.00	Accumulated depreciation	0	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	0	0	0	0	26.00
27.00	HIT designated Assets	0	0	0	0	27.00
28.00	Accumulated depreciation	0	0	0	0	28.00
29.00	Minor equipment-nondepreciable	0	0	0	0	29.00
30.00	Total fixed assets (sum of lines 12-29)	423,127,000	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	139,145,000	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	35,636,000	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	174,781,000	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	716,917,000	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	16,749,000	0	0	0	37.00
38.00	Salaries, wages, and fees payable	19,776,000	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	6,935,000	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	40,087,000	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	83,547,000	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	419,236,000	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	6,686,000	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	425,922,000	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	509,469,000	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	207,448,000				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0		56.00
57.00	Plant fund balance - invested in plant				0	57.00
58.00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58.00
59.00	Total fund balances (sum of lines 52 thru 58)	207,448,000	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	716,917,000	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 140213

Period:
From 10/01/2014
To 09/30/2015

Worksheet G-1

Date/Time Prepared:
2/19/2016 2:55 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		266,833,000		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		9,318,364			2.00
3.00	Total (sum of line 1 and line 2)		276,151,364		0	3.00
4.00	NET ASSETS RELEASED FROM RESTRICTION	473,000		0		4.00
5.00	PERMANENTLY RESTRICTED ASSETS	54,636		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		527,636		0	10.00
11.00	Subtotal (line 3 plus line 10)		276,679,000		0	11.00
12.00	DECREASE IN TEMPORARILY RESTRICTED A	218,000		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		218,000		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		276,461,000		0	19.00
		Endowment Fund		Plant Fund		
		6.00	7.00	8.00		
1.00	Fund balances at beginning of period	0		0		1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)					2.00
3.00	Total (sum of line 1 and line 2)	0		0		3.00
4.00	NET ASSETS RELEASED FROM RESTRICTION		0			4.00
5.00	PERMANENTLY RESTRICTED ASSETS		0			5.00
6.00			0			6.00
7.00			0			7.00
8.00			0			8.00
9.00			0			9.00
10.00	Total additions (sum of line 4-9)	0		0		10.00
11.00	Subtotal (line 3 plus line 10)	0		0		11.00
12.00	DECREASE IN TEMPORARILY RESTRICTED A		0			12.00
13.00			0			13.00
14.00			0			14.00
15.00			0			15.00
16.00			0			16.00
17.00			0			17.00
18.00	Total deductions (sum of lines 12-17)	0		0		18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0		19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 140213

Period:
From 10/01/2014
To 09/30/2015

Worksheet G-2
Parts I & II
Date/Time Prepared:
2/19/2016 2:55 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	63,936,501		63,936,501	1.00
2.00	SUBPROVIDER - IPF	6,213,133		6,213,133	2.00
3.00	SUBPROVIDER - IRF	9,541,987		9,541,987	3.00
4.00	SUBPROVIDER	0		0	4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY	0		0	7.00
8.00	NURSING FACILITY	0		0	8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	79,691,621		79,691,621	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	18,046,777		18,046,777	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)	18,046,777		18,046,777	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	97,738,398		97,738,398	17.00
18.00	Ancillary services	389,559,926	513,896,353	903,456,279	18.00
19.00	Outpatient services	28,517,622	79,219,056	107,736,678	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY		5,509,205	5,509,205	22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC		0	0	24.00
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	515,815,946	598,624,614	1,114,440,560	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		328,286,319		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		328,286,319		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 140213

Period:
From 10/01/2014
To 09/30/2015

Worksheet G-3

Date/Time Prepared:
2/19/2016 2:55 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	1,114,440,560	1.00
2.00	Less contractual allowances and discounts on patients' accounts	791,265,877	2.00
3.00	Net patient revenues (line 1 minus line 2)	323,174,683	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	328,286,319	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-5,111,636	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	0	7.00
8.00	Revenues from telephone and other miscellaneous communication services	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	0	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	0	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	0	23.00
24.00	MISC - OTHER REVENUE	12,411,000	24.00
24.01	NON-OPERATING INCOME	2,019,000	24.01
25.00	Total other income (sum of lines 6-24)	14,430,000	25.00
26.00	Total (line 5 plus line 25)	9,318,364	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	9,318,364	29.00

ANALYSIS OF PROVIDER-BASED HOME HEALTH AGENCY COSTS

Provider CCN: 140213

Period: From 10/01/2014

Worksheet H

HHA CCN: 147452

To 09/30/2015

Date/Time Prepared: 2/19/2016 2:55 am

Home Health Agency I

PPS

	Salaries	Employee Benefits	Transportation (see instructions)	Contracted/Purchased Services	Other Costs	Total (sum of col.s. 1 thru 5)	
	1.00	2.00	3.00	4.00	5.00	6.00	
GENERAL SERVICE COST CENTERS							
1.00			0		0	0	1.00
2.00			0		0	0	2.00
3.00	0	0	0	0	0	0	3.00
4.00	0	0	0	0	0	0	4.00
5.00	492,047	0	43	647	34,231	526,968	5.00
HHA REIMBURSABLE SERVICES							
6.00	1,083,299	0	68,514	0	73,551	1,225,364	6.00
7.00	0	0	0	912,161	0	912,161	7.00
8.00	0	0	0	0	0	0	8.00
9.00	0	0	0	0	0	0	9.00
10.00	4,380	0	0	0	0	4,380	10.00
11.00	47,351	0	7,224	0	0	54,575	11.00
12.00	0	0	0	0	0	0	12.00
13.00	0	0	0	0	0	0	13.00
14.00	0	0	0	0	0	0	14.00
HHA NONREIMBURSABLE SERVICES							
15.00	0	0	0	0	0	0	15.00
16.00	0	0	0	0	0	0	16.00
17.00	0	0	0	0	0	0	17.00
18.00	0	0	0	0	0	0	18.00
19.00	0	0	0	0	0	0	19.00
20.00	0	0	0	0	0	0	20.00
21.00	0	0	0	0	0	0	21.00
22.00	0	0	0	0	0	0	22.00
23.00	0	0	0	0	0	0	23.00
24.00	1,627,077	0	75,781	912,808	107,782	2,723,448	24.00
	Reclassifi cation	Reclassifi ed Trial Balance (col. 6 + col. 7)	Adjustments	Net Expenses for Allocation (col. 8 + col. 9)			
	7.00	8.00	9.00	10.00			
GENERAL SERVICE COST CENTERS							
1.00	0	0	0	0			1.00
2.00	0	0	0	0			2.00
3.00	0	0	0	0			3.00
4.00	0	0	0	0			4.00
5.00	35,000	561,968	0	561,968			5.00
HHA REIMBURSABLE SERVICES							
6.00	0	1,225,364	0	1,225,364			6.00
7.00	-26,745	885,416	0	885,416			7.00
8.00	0	0	0	0			8.00
9.00	0	0	0	0			9.00
10.00	0	4,380	0	4,380			10.00
11.00	0	54,575	0	54,575			11.00
12.00	0	0	0	0			12.00
13.00	0	0	0	0			13.00
14.00	0	0	0	0			14.00
HHA NONREIMBURSABLE SERVICES							
15.00	0	0	0	0			15.00
16.00	0	0	0	0			16.00
17.00	0	0	0	0			17.00
18.00	0	0	0	0			18.00
19.00	0	0	0	0			19.00
20.00	0	0	0	0			20.00
21.00	0	0	0	0			21.00
22.00	0	0	0	0			22.00
23.00	0	0	0	0			23.00
24.00	8,255	2,731,703	0	2,731,703			24.00

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

COST ALLOCATION - HHA GENERAL SERVICE COST		Provider CCN: 140213	Period: From 10/01/2014 To 09/30/2015	Worksheet H-1 Part I Date/Time Prepared: 2/19/2016 2:55 am
		HHA CCN: 147452	Home Health Agency I	PPS

	Net Expenses for Cost Allocation (from Wkst. H, col. 10)	Capital Related Costs		Plant Operation & Maintenance	Transportation	Subtotal (cols. 0-4)		
		Bldgs & Fixtures	Movable Equipment					
		1.00	2.00					3.00
GENERAL SERVICE COST CENTERS								
1.00	Capital Related - Bldg. & Fixtures	0	0			0	1.00	
2.00	Capital Related - Movable Equipment	0	0			0	2.00	
3.00	Plant Operation & Maintenance	0	0	0		0	3.00	
4.00	Transportation	0	0	0	0	0	4.00	
5.00	Administrative and General	561,968	0	0	0	561,968	5.00	
HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	1,225,364	0	0	0	1,225,364	6.00	
7.00	Physical Therapy	885,416	0	0	0	885,416	7.00	
8.00	Occupational Therapy	0	0	0	0	0	8.00	
9.00	Speech Pathology	0	0	0	0	0	9.00	
10.00	Medical Social Services	4,380	0	0	0	4,380	10.00	
11.00	Home Health Aide	54,575	0	0	0	54,575	11.00	
12.00	Supplies (see instructions)	0	0	0	0	0	12.00	
13.00	Drugs	0	0	0	0	0	13.00	
14.00	DME	0	0	0	0	0	14.00	
HHA NONREIMBURSABLE SERVICES								
15.00	Home Dialysis Aide Services	0	0	0	0	0	15.00	
16.00	Respiratory Therapy	0	0	0	0	0	16.00	
17.00	Private Duty Nursing	0	0	0	0	0	17.00	
18.00	Clinic	0	0	0	0	0	18.00	
19.00	Health Promotion Activities	0	0	0	0	0	19.00	
20.00	Day Care Program	0	0	0	0	0	20.00	
21.00	Home Delivered Meals Program	0	0	0	0	0	21.00	
22.00	Homemaker Service	0	0	0	0	0	22.00	
23.00	All Others (specify)	0	0	0	0	0	23.00	
24.00	Total (sum of lines 1-23)	2,731,703	0	0	0	2,731,703	24.00	
		Administrative & General	Total (cols. 4A + 5)					
		5.00	6.00					
GENERAL SERVICE COST CENTERS								
1.00	Capital Related - Bldg. & Fixtures						1.00	
2.00	Capital Related - Movable Equipment						2.00	
3.00	Plant Operation & Maintenance						3.00	
4.00	Transportation						4.00	
5.00	Administrative and General	561,968					5.00	
HHA REIMBURSABLE SERVICES								
6.00	Skilled Nursing Care	317,374	1,542,738				6.00	
7.00	Physical Therapy	229,325	1,114,741				7.00	
8.00	Occupational Therapy	0	0				8.00	
9.00	Speech Pathology	0	0				9.00	
10.00	Medical Social Services	1,134	5,514				10.00	
11.00	Home Health Aide	14,135	68,710				11.00	
12.00	Supplies (see instructions)	0	0				12.00	
13.00	Drugs	0	0				13.00	
14.00	DME	0	0				14.00	
HHA NONREIMBURSABLE SERVICES								
15.00	Home Dialysis Aide Services	0	0				15.00	
16.00	Respiratory Therapy	0	0				16.00	
17.00	Private Duty Nursing	0	0				17.00	
18.00	Clinic	0	0				18.00	
19.00	Health Promotion Activities	0	0				19.00	
20.00	Day Care Program	0	0				20.00	
21.00	Home Delivered Meals Program	0	0				21.00	
22.00	Homemaker Service	0	0				22.00	
23.00	All Others (specify)	0	0				23.00	
24.00	Total (sum of lines 1-23)		2,731,703				24.00	

COST ALLOCATION - HHA STATISTICAL BASIS

Provider CCN: 140213

Period:

Worksheet H-1

HHA CCN: 147452

From 10/01/2014

Part II

To 09/30/2015

Date/Time Prepared:

Home Health Agency I

PPS

	Capital Related Costs		Plant Operation & Maintenance (SQUARE FEET)	Transportation (MILEAGE)	Reconciliation	Administrative & General (ACCUM. COST)	
	Bl dgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)					
	1.00	2.00					
GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. & Fixtures	0			0		1.00
2.00	Capital Related - Movable Equipment		0		0		2.00
3.00	Plant Operation & Maintenance	0	0	0	0		3.00
4.00	Transportation (see instructions)	0	0	0	0		4.00
5.00	Administrative and General	0	0	0	0	-561,968	2,169,735
HHA REIMBURSABLE SERVICES							
6.00	Skilled Nursing Care	0	0	0	0	0	1,225,364
7.00	Physical Therapy	0	0	0	0	0	885,416
8.00	Occupational Therapy	0	0	0	0	0	0
9.00	Speech Pathology	0	0	0	0	0	0
10.00	Medical Social Services	0	0	0	0	0	4,380
11.00	Home Health Aide	0	0	0	0	0	54,575
12.00	Supplies (see instructions)	0	0	0	0	0	0
13.00	Drugs	0	0	0	0	0	0
14.00	DME	0	0	0	0	0	0
HHA NONREIMBURSABLE SERVICES							
15.00	Home Dialysis Aide Services	0	0	0	0	0	0
16.00	Respiratory Therapy	0	0	0	0	0	0
17.00	Private Duty Nursing	0	0	0	0	0	0
18.00	Clinic	0	0	0	0	0	0
19.00	Health Promotion Activities	0	0	0	0	0	0
20.00	Day Care Program	0	0	0	0	0	0
21.00	Home Delivered Meals Program	0	0	0	0	0	0
22.00	Homemaker Service	0	0	0	0	0	0
23.00	All Others (specify)	0	0	0	0	0	0
24.00	Total (sum of lines 1-23)	0	0	0	0	-561,968	2,169,735
25.00	Cost To Be Allocated (per Worksheet H-1, Part I)	0	0	0	0		561,968
26.00	Unit Cost Multiplier	0.000000	0.000000	0.000000	0.000000		0.259003

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 140213

Period: From 10/01/2014

Worksheet H-2

HHA CCN: 147452

To 09/30/2015

Part I
Date/Time Prepared:
2/19/2016 2:55 am

Home Health Agency I

PPS

Cost Center Description	HHA Trial Balance (1)	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	
		BLDG & FIXT	MVBLE EQUIP					
		1.00	2.00	4.00				
1.00 Administrative and General	0	0	1,299	537,255	538,554	142,262	1.00	
2.00 Skilled Nursing Care	1,542,738	0	0	0	1,542,738	407,522	2.00	
3.00 Physical Therapy	1,114,741	0	0	0	1,114,741	294,464	3.00	
4.00 Occupational Therapy	0	0	0	0	0	0	4.00	
5.00 Speech Pathology	0	0	0	0	0	0	5.00	
6.00 Medical Social Services	5,514	0	0	0	5,514	1,457	6.00	
7.00 Home Health Aide	68,710	0	0	0	68,710	18,150	7.00	
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00	
9.00 Drugs	0	0	0	0	0	0	9.00	
10.00 DME	0	0	0	0	0	0	10.00	
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00	
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00	
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00	
14.00 Clinic	0	0	0	0	0	0	14.00	
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00	
16.00 Day Care Program	0	0	0	0	0	0	16.00	
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00	
18.00 Homemaker Service	0	0	0	0	0	0	18.00	
19.00 All Others (specify)	0	0	0	0	0	0	19.00	
20.00 Total (sum of lines 1-19) (2)	2,731,703	0	1,299	537,255	3,270,257	863,855	20.00	
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.					0.000000		21.00	
Cost Center Description	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DIETARY	CAFETERIA	NURSING ADMINISTRATION		
	7.00	8.00	9.00	10.00	11.00	13.00		
1.00 Administrative and General	0	0	0	0	0	141,274	1.00	
2.00 Skilled Nursing Care	0	0	0	0	0	0	2.00	
3.00 Physical Therapy	0	0	0	0	0	0	3.00	
4.00 Occupational Therapy	0	0	0	0	0	0	4.00	
5.00 Speech Pathology	0	0	0	0	0	0	5.00	
6.00 Medical Social Services	0	0	0	0	0	0	6.00	
7.00 Home Health Aide	0	0	0	0	0	0	7.00	
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00	
9.00 Drugs	0	0	0	0	0	0	9.00	
10.00 DME	0	0	0	0	0	0	10.00	
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00	
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00	
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00	
14.00 Clinic	0	0	0	0	0	0	14.00	
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00	
16.00 Day Care Program	0	0	0	0	0	0	16.00	
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00	
18.00 Homemaker Service	0	0	0	0	0	0	18.00	
19.00 All Others (specify)	0	0	0	0	0	0	19.00	
20.00 Total (sum of lines 1-19) (2)	0	0	0	0	0	141,274	20.00	
21.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00	

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS

Provider CCN: 140213

Period: From 10/01/2014

Worksheet H-2

HHA CCN: 147452

To 09/30/2015

Part I
Date/Time Prepared: 2/19/2016 2:55 am

Home Health Agency I

PPS

Cost Center Description		CENTRAL SERVICES & SUPPLY	PHARMACY	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	PARAMED ED PRGM	Subtotal	
		14.00	15.00	16.00	17.00	23.00	24.00	
1.00	Administrative and General	0	837	0	0	0	822,927	1.00
2.00	Skilled Nursing Care	0	0	0	0	0	1,950,260	2.00
3.00	Physical Therapy	0	0	0	0	0	1,409,205	3.00
4.00	Occupational Therapy	0	0	0	0	0	0	4.00
5.00	Speech Pathology	0	0	0	0	0	0	5.00
6.00	Medical Social Services	0	0	0	0	0	6,971	6.00
7.00	Home Health Aide	0	0	0	0	0	86,860	7.00
8.00	Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00	Drugs	0	0	0	0	0	0	9.00
10.00	DME	0	0	0	0	0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00	Respiratory Therapy	0	0	0	0	0	0	12.00
13.00	Private Duty Nursing	0	0	0	0	0	0	13.00
14.00	Clinic	0	0	0	0	0	0	14.00
15.00	Health Promotion Activities	0	0	0	0	0	0	15.00
16.00	Day Care Program	0	0	0	0	0	0	16.00
17.00	Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00	Homemaker Service	0	0	0	0	0	0	18.00
19.00	All Others (specify)	0	0	0	0	0	0	19.00
20.00	Total (sum of lines 1-19) (2)	0	837	0	0	0	4,276,223	20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.00
Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Subtotal	Allocated HHA A&G (see Part II)	Total HHA Costs			
		25.00	26.00	27.00	28.00			
1.00	Administrative and General	0	822,927					1.00
2.00	Skilled Nursing Care	0	1,950,260	464,751	2,415,011			2.00
3.00	Physical Therapy	0	1,409,205	335,816	1,745,021			3.00
4.00	Occupational Therapy	0	0	0	0			4.00
5.00	Speech Pathology	0	0	0	0			5.00
6.00	Medical Social Services	0	6,971	1,661	8,632			6.00
7.00	Home Health Aide	0	86,860	20,699	107,559			7.00
8.00	Supplies (see instructions)	0	0	0	0			8.00
9.00	Drugs	0	0	0	0			9.00
10.00	DME	0	0	0	0			10.00
11.00	Home Dialysis Aide Services	0	0	0	0			11.00
12.00	Respiratory Therapy	0	0	0	0			12.00
13.00	Private Duty Nursing	0	0	0	0			13.00
14.00	Clinic	0	0	0	0			14.00
15.00	Health Promotion Activities	0	0	0	0			15.00
16.00	Day Care Program	0	0	0	0			16.00
17.00	Home Delivered Meals Program	0	0	0	0			17.00
18.00	Homemaker Service	0	0	0	0			18.00
19.00	All Others (specify)	0	0	0	0			19.00
20.00	Total (sum of lines 1-19) (2)	0	4,276,223	822,927	4,276,223			20.00
21.00	Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.			0.238302				21.00

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

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

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 140213
HHA CCN: 147452

Period:
From 10/01/2014
To 09/30/2015

Worksheet H-2
Part II
Date/Time Prepared:
2/19/2016 2:55 am
PPS

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	OPERATION OF PLANT (SQUARE FEET)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)					
	1.00	2.00					
1.00 Administrative and General	0	1,193	1,627,079	0	538,554	0	1.00
2.00 Skilled Nursing Care	0	0	0	0	1,542,738	0	2.00
3.00 Physical Therapy	0	0	0	0	1,114,741	0	3.00
4.00 Occupational Therapy	0	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	5,514	0	6.00
7.00 Home Health Aide	0	0	0	0	68,710	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19)	0	1,193	1,627,079		3,270,257	0	20.00
21.00 Total cost to be allocated	0	1,299	537,255		863,855	0	21.00
22.00 Unit cost multiplier	0.000000	1.088852	0.330196		0.264155	0.000000	22.00
Cost Center Description	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	CAFETERIA (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NRSING)	CENTRAL SERVICES & SUPPLY (COSTED REQUI S.)	
	8.00	9.00	10.00	11.00	13.00	14.00	
1.00 Administrative and General	0	0	0	0	44,600	0	1.00
2.00 Skilled Nursing Care	0	0	0	0	0	0	2.00
3.00 Physical Therapy	0	0	0	0	0	0	3.00
4.00 Occupational Therapy	0	0	0	0	0	0	4.00
5.00 Speech Pathology	0	0	0	0	0	0	5.00
6.00 Medical Social Services	0	0	0	0	0	0	6.00
7.00 Home Health Aide	0	0	0	0	0	0	7.00
8.00 Supplies (see instructions)	0	0	0	0	0	0	8.00
9.00 Drugs	0	0	0	0	0	0	9.00
10.00 DME	0	0	0	0	0	0	10.00
11.00 Home Dialysis Aide Services	0	0	0	0	0	0	11.00
12.00 Respiratory Therapy	0	0	0	0	0	0	12.00
13.00 Private Duty Nursing	0	0	0	0	0	0	13.00
14.00 Clinic	0	0	0	0	0	0	14.00
15.00 Health Promotion Activities	0	0	0	0	0	0	15.00
16.00 Day Care Program	0	0	0	0	0	0	16.00
17.00 Home Delivered Meals Program	0	0	0	0	0	0	17.00
18.00 Homemaker Service	0	0	0	0	0	0	18.00
19.00 All Others (specify)	0	0	0	0	0	0	19.00
20.00 Total (sum of lines 1-19)	0	0	0	0	44,600	0	20.00
21.00 Total cost to be allocated	0	0	0	0	141,274	0	21.00
22.00 Unit cost multiplier	0.000000	0.000000	0.000000	0.000000	3.167578	0.000000	22.00

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL BASIS

Provider CCN: 140213
HHA CCN: 147452

Period:
From 10/01/2014
To 09/30/2015

Worksheet H-2
Part II
Date/Time Prepared:
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Cost Center Description	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	PARAMED PRGM (ASSIGNED TIME)		
	15.00	16.00	17.00	23.00		
1.00 Administrative and General	1,134	0	0	0		1.00
2.00 Skilled Nursing Care	0	0	0	0		2.00
3.00 Physical Therapy	0	0	0	0		3.00
4.00 Occupational Therapy	0	0	0	0		4.00
5.00 Speech Pathology	0	0	0	0		5.00
6.00 Medical Social Services	0	0	0	0		6.00
7.00 Home Health Aide	0	0	0	0		7.00
8.00 Supplies (see instructions)	0	0	0	0		8.00
9.00 Drugs	0	0	0	0		9.00
10.00 DME	0	0	0	0		10.00
11.00 Home Dialysis Aide Services	0	0	0	0		11.00
12.00 Respiratory Therapy	0	0	0	0		12.00
13.00 Private Duty Nursing	0	0	0	0		13.00
14.00 Clinic	0	0	0	0		14.00
15.00 Health Promotion Activities	0	0	0	0		15.00
16.00 Day Care Program	0	0	0	0		16.00
17.00 Home Delivered Meals Program	0	0	0	0		17.00
18.00 Homemaker Service	0	0	0	0		18.00
19.00 All Others (specify)	0	0	0	0		19.00
20.00 Total (sum of lines 1-19)	1,134	0	0	0		20.00
21.00 Total cost to be allocated	837	0	0	0		21.00
22.00 Unit cost multiplier	0.738095	0.000000	0.000000	0.000000		22.00

APPORTIONMENT OF PATIENT SERVICE COSTS				Provider CCN: 140213	Period: From 10/01/2014 To 09/30/2015	Worksheet H-3 Part I Date/Time Prepared: 2/19/2016 2:55 am		
				HHA CCN: 147452	Title XVIII	Home Health Agency I		
Cost Center Description	From, Wkst. H-2, Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (col. 1 + 2)	Total Visits	Average Cost Per Visit (col. 3 + col. 4)		
	0	1.00	2.00	3.00	4.00	5.00		
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	2.00	2,415,011		2,415,011	12,243	197.26	1.00
2.00	Physical Therapy	3.00	1,745,021	0	1,745,021	7,433	234.77	2.00
3.00	Occupational Therapy	4.00	0	0	0	1,883	0.00	3.00
4.00	Speech Pathology	5.00	0	0	0	329	0.00	4.00
5.00	Medical Social Services	6.00	8,632		8,632	79	109.27	5.00
6.00	Home Health Aide	7.00	107,559		107,559	1,473	73.02	6.00
7.00	Total (sum of lines 1-6)		4,276,223	0	4,276,223	23,440		7.00
Program Visits								
Part B								
Not Subject to Deductibles & Coinsurance								
Subject to Deductibles								
Cost Center Description	Cost Limits	CBSA No. (1)	Part A					
	0	1.00	2.00	3.00	4.00	5.00		
Limitation Cost Computation								
8.00	Skilled Nursing Care		16974	0	9,551			8.00
9.00	Physical Therapy		16974	0	5,833			9.00
10.00	Occupational Therapy		16974	0	1,648			10.00
11.00	Speech Pathology		16974	0	285			11.00
12.00	Medical Social Services		16974	0	81			12.00
13.00	Home Health Aide		16974	0	1,404			13.00
14.00	Total (sum of lines 8-13)			0	18,802			14.00
Program Visits								
Part B								
Not Subject to Deductibles & Coinsurance								
Subject to Deductibles & Coinsurance								
Cost Center Description	From Wkst. H-2 Part I, col. 28, line	Facility Costs (from Wkst. H-2, Part I)	Shared Ancillary Costs (from Part II)	Total HHA Costs (col. 1 + 2)	Total Charges (from HHA Record)	Ratio (col. 3 + col. 4)		
	0	1.00	2.00	3.00	4.00	5.00		
Supplies and Drugs Cost Computations								
15.00	Cost of Medical Supplies	8.00	0	0	0	0.000000	15.00	
16.00	Cost of Drugs	9.00	0	0	0	0.000000	16.00	
Program Visits								
Part B								
Not Subject to Deductibles & Coinsurance								
Subject to Deductibles & Coinsurance								
Cost Center Description	Part A			Cost of Services				
	6.00	7.00	8.00	9.00	10.00	11.00		
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00	Skilled Nursing Care	0	9,551		0	1,884,030	1.00	
2.00	Physical Therapy	0	5,833		0	1,369,413	2.00	
3.00	Occupational Therapy	0	1,648		0	0	3.00	
4.00	Speech Pathology	0	285		0	0	4.00	
5.00	Medical Social Services	0	81		0	8,851	5.00	
6.00	Home Health Aide	0	1,404		0	102,520	6.00	
7.00	Total (sum of lines 1-6)	0	18,802		0	3,364,814	7.00	
Program Visits								
Part B								
Not Subject to Deductibles & Coinsurance								
Subject to Deductibles & Coinsurance								
Cost Center Description								
	6.00	7.00	8.00	9.00	10.00	11.00		
Limitation Cost Computation								
8.00	Skilled Nursing Care						8.00	
9.00	Physical Therapy						9.00	
10.00	Occupational Therapy						10.00	
11.00	Speech Pathology						11.00	
12.00	Medical Social Services						12.00	
13.00	Home Health Aide						13.00	
14.00	Total (sum of lines 8-13)						14.00	

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 140213
HHA CCN: 147452

Period:
From 10/01/2014
To 09/30/2015

Worksheet H-3
Part I
Date/Time Prepared:
2/19/2016 2:55 am
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Title XVIII

Home Health Agency I

Cost Center Description	Program Covered Charges			Cost of Services	Part B	Subject to Deductibles & Coinsurance		
	Part A	Part B						
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
	6.00	7.00	8.00	9.00	10.00	11.00		
Supplies and Drugs Cost Computations								
15.00 Cost of Medical Supplies	0	0	0	0	0	0	15.00	
16.00 Cost of Drugs		0	0		0	0	16.00	
Cost Center Description	Total Program Cost (sum of col.s. 9-10)							
	12.00							
PART I - COMPUTATION OF LESSER OF AGGREGATE PROGRAM COST, AGGREGATE OF THE PROGRAM LIMITATION COST, OR BENEFICIARY COST LIMITATION								
Cost Per Visit Computation								
1.00 Skilled Nursing Care	1,884,030							1.00
2.00 Physical Therapy	1,369,413							2.00
3.00 Occupational Therapy	0							3.00
4.00 Speech Pathology	0							4.00
5.00 Medical Social Services	8,851							5.00
6.00 Home Health Aide	102,520							6.00
7.00 Total (sum of lines 1-6)	3,364,814							7.00
Cost Center Description								
	12.00							
Limitation Cost Computation								
8.00 Skilled Nursing Care								8.00
9.00 Physical Therapy								9.00
10.00 Occupational Therapy								10.00
11.00 Speech Pathology								11.00
12.00 Medical Social Services								12.00
13.00 Home Health Aide								13.00
14.00 Total (sum of lines 8-13)								14.00

APPORTIONMENT OF PATIENT SERVICE COSTS

Provider CCN: 140213

Period:

Worksheet H-3

HHA CCN: 147452

From 10/01/2014

Part II

To 09/30/2015

Date/Time Prepared:

Home Health Agency I

PPS

Cost Center Description	From Wkst. C, Part I, col. 9, line	Cost to Charge Ratio	Total HHA Charge (from provider records)	HHA Shared Ancillary Costs (col. 1 x col. 2)	Transfer to Part I as Indicated		
	0	1.00	2.00	3.00	4.00		
PART II - APPORTIONMENT OF COST OF HHA SERVICES FURNISHED BY SHARED HOSPITAL DEPARTMENTS							
1.00	Physical Therapy	66.00	0.329019	0	0	col. 2, line 2.00	1.00
2.00	Occupational Therapy	67.00	0.235077	0	0	col. 2, line 3.00	2.00
3.00	Speech Pathology	68.00	0.000000	0	0	col. 2, line 4.00	3.00
4.00	Cost of Medical Supplies	71.00	0.470251	0	0	col. 2, line 15.00	4.00
5.00	Cost of Drugs	73.00	0.331115	0	0	col. 2, line 16.00	5.00

CALCULATION OF HHA REIMBURSEMENT SETTLEMENT		Provider CCN: 140213 HHA CCN: 147452	Period: From 10/01/2014 To 09/30/2015	Worksheet H-4 Part I-II Date/Time Prepared: 2/19/2016 2:55 am
		Title XVII I	Home Health Agency I	PPS
		Part A	Part B	
			Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance
		1.00	2.00	3.00
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHARGES				
Reasonable Cost of Part A & Part B Services				
1.00	Reasonable cost of services (see instructions)	0	0	0
2.00	Total charges	0	4,183,361	0
Customary Charges				
3.00	Amount actually collected from patients liable for payment for services on a charge basis (from your records)	0	0	0
4.00	Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR §413.13(b)	0	0	0
5.00	Ratio of line 3 to line 4 (not to exceed 1.000000)	0.000000	0.000000	0.000000
6.00	Total customary charges (see instructions)	0	4,183,361	0
7.00	Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1)	0	4,183,361	0
8.00	Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6)	0	0	0
9.00	Primary payer amounts	0	0	0
			Part A Services	Part B Services
			1.00	2.00
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT				
10.00	Total reasonable cost (see instructions)		0	0
11.00	Total PPS Reimbursement - Full Episodes without Outliers		0	2,749,094
12.00	Total PPS Reimbursement - Full Episodes with Outliers		0	125,527
13.00	Total PPS Reimbursement - LUPA Episodes		0	30,252
14.00	Total PPS Reimbursement - PEP Episodes		0	69,574
15.00	Total PPS Outlier Reimbursement - Full Episodes with Outliers		0	22,099
16.00	Total PPS Outlier Reimbursement - PEP Episodes		0	1,351
17.00	Total Other Payments		0	0
18.00	DME Payments		0	0
19.00	Oxygen Payments		0	0
20.00	Prosthetic and Orthotic Payments		0	0
21.00	Part B deductibles billed to Medicare patients (exclude coinsurance)		0	0
22.00	Subtotal (sum of lines 10 thru 20 minus line 21)		0	2,997,897
23.00	Excess reasonable cost (from line 8)		0	0
24.00	Subtotal (line 22 minus line 23)		0	2,997,897
25.00	Coinsurance billed to program patients (from your records)			0
26.00	Net cost (line 24 minus line 25)		0	2,997,897
27.00	Reimbursable bad debts (from your records)			0
28.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)			0
29.00	Total costs - current cost reporting period (line 26 plus line 27)		0	2,997,897
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0
30.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	0
31.00	Subtotal (see instructions)		0	2,997,897
31.01	Sequestration adjustment (see instructions)		0	59,956
32.00	Interim payments (see instructions)		0	2,937,941
33.00	Tentative settlement (for contractor use only)		0	0
34.00	Balance due provider/program (line 31 minus lines 31.01, 32, and 33)		0	0
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	0

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

Provider CCN: 140213
HHA CCN: 147452

Period:
From 10/01/2014
To 09/30/2015

Worksheet H-5
Date/Time Prepared:
2/19/2016 2:55 am
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		Inpatient Part A		Part B		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00	Total interim payments paid to provider		0		2,937,941	1.00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2.00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
Program to Provider						
3.01			0		0	3.01
3.02			0		0	3.02
3.03			0		0	3.03
3.04			0		0	3.04
3.05			0		0	3.05
Provider to Program						
3.50			0		0	3.50
3.51			0		0	3.51
3.52			0		0	3.52
3.53			0		0	3.53
3.54			0		0	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3.99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)		0		2,937,941	4.00
TO BE COMPLETED BY CONTRACTOR						
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
Program to Provider						
5.01			0		0	5.01
5.02			0		0	5.02
5.03			0		0	5.03
Provider to Program						
5.50			0		0	5.50
5.51			0		0	5.51
5.52			0		0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER		0		0	6.01
6.02	SETTLEMENT TO PROGRAM		0		0	6.02
7.00	Total Medicare program liability (see instructions)		0		2,937,941	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
				0	1.00	2.00
8.00	Name of Contractor					8.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 140213	Period: From 10/01/2014 To 09/30/2015	Worksheet L Parts I-III Date/Time Prepared: 2/19/2016 2:55 am
		Title XVII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		4,484,710	1.00
1.01	Model 4 BPCI Capital DRG other than outlier		0	1.01
2.00	Capital DRG outlier payments		194,584	2.00
2.01	Model 4 BPCI Capital DRG outlier payments		0	2.01
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		176.99	3.00
4.00	Number of interns & residents (see instructions)		0.00	4.00
5.00	Indirect medical education percentage (see instructions)		0.00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01)(see instructions)		0	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		2.66	7.00
8.00	Percentage of Medicaid patient days to total days (see instructions)		14.40	8.00
9.00	Sum of lines 7 and 8		17.06	9.00
10.00	Allowable disproportionate share percentage (see instructions)		3.51	10.00
11.00	Disproportionate share adjustment (see instructions)		157,413	11.00
12.00	Total prospective capital payments (see instructions)		4,836,707	12.00
				1.00
PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)		0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)		0	2.00
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3.00
4.00	Capital cost payment factor (see instructions)		0	4.00
5.00	Total inpatient program capital cost (line 3 x line 4)		0	5.00
				1.00
PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)		0	1.00
2.00	Program inpatient capital costs for extraordinary circumstances (see instructions)		0	2.00
3.00	Net program inpatient capital costs (line 1 minus line 2)		0	3.00
4.00	Applicable exception percentage (see instructions)		0.00	4.00
5.00	Capital cost for comparison to payments (line 3 x line 4)		0	5.00
6.00	Percentage adjustment for extraordinary circumstances (see instructions)		0.00	6.00
7.00	Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)		0	7.00
8.00	Capital minimum payment level (line 5 plus line 7)		0	8.00
9.00	Current year capital payments (from Part I, line 12, as applicable)		0	9.00
10.00	Current year comparison of capital minimum payment level to capital payments (line 8 less line 9)		0	10.00
11.00	Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)		0	11.00
12.00	Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)		0	12.00
13.00	Current year exception payment (if line 12 is positive, enter the amount on this line)		0	13.00
14.00	Carryover of accumulated capital minimum payment level over capital payment for the following period (if line 12 is negative, enter the amount on this line)		0	14.00
15.00	Current year allowable operating and capital payment (see instructions)		0	15.00
16.00	Current year operating and capital costs (see instructions)		0	16.00
17.00	Current year exception offset amount (see instructions)		0	17.00