

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: 140124	Period: From 12/01/2011 To 11/30/2012	Worksheet S Parts I-III Date/Time Prepared: 4/30/2013 11:03 am
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PART I - COST REPORT STATUS

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: 4/30/2013 Time: 11:03 am
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: 7. Contractor No. 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN 10. NPR Date: 11. Contractor's Vendor Code: 4 12. <input type="checkbox"/> If line 5, column 1 is 4: Enter number of times reopened = 0-9.

PART II - CERTIFICATION

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by JOHN H. STROGER JR. HOSP OF COOK CTY (140124) for the cost reporting period beginning 12/01/2011 and ending 11/30/2012 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

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

Title

Date

Cost Center Description	Title V		Title XVIII		HIT	Title XIX	
	1.00	2.00	Part A	Part B			
PART III - SETTLEMENT SUMMARY							
1.00 Hospital	0	1,094,442		108,200	177,139	0	1.00
2.00 Subprovider - IPF	0	0		0		0	2.00
3.00 Subprovider - IRF	0	0		0		0	3.00
4.00 SUBPROVIDER I	0	0		0		0	4.00
5.00 Swing bed - SNF	0	0		0		0	5.00
6.00 Swing bed - NF	0	0		0		0	6.00
7.00 SKILLED NURSING FACILITY	0	0		0		0	7.00
8.00 NURSING FACILITY	0	0		0		0	8.00
9.00 HOME HEALTH AGENCY I	0	0		0		0	9.00
10.00 RURAL HEALTH CLINIC I	0	0		0		0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0	0		0		0	11.00
12.00 CMHC I	0	0		0		0	12.00
200.00 Total	0	1,094,442		108,200	177,139	0	200.00

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

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Encryption Information
ECR: Date: 4/30/2013 Time: 11:03 am
s4PgA0m3u6yZGGT: Mk0e9D8fEqUCx0
lOYJA0Ayxom1VSBwSNEs5a1gQFeKI U
6hi 91hli hK04sDMJ
PI: Date: 4/30/2013 Time: 11:03 am
PQPYv5i 0kDXW2dXcgNLKpLHKR1bQQO
nHei q0aA: eUNsl GFu3yQTGeg6ynDnE
Hj MPVBFWdx0vTui w

(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	1,094,442	108,200	177,139	0 1.00
2.00	Subprovider - IPF	0	0	0	0	0 2.00
3.00	Subprovider - IRF	0	0	0	0	0 3.00
4.00	SUBPROVIDER I	0	0	0	0	0 4.00
5.00	Swing bed - SNF	0	0	0	0	0 5.00
6.00	Swing bed - NF	0	0	0	0	0 6.00
7.00	SKILLED NURSING FACILITY	0	0	0	0	0 7.00
8.00	NURSING FACILITY	0	0	0	0	0 8.00
9.00	HOME HEALTH AGENCY I	0	0	0	0	0 9.00
10.00	RURAL HEALTH CLINIC I	0	0	0	0	0 10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0	0	0	0	0 11.00
12.00	CMHC I	0	0	0	0	0 12.00
200.00	Total	0	1,094,442	108,200	177,139	0 200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140124	Period: From 12/01/2011 To 11/30/2012	Worksheet S-2 Part I Date/Time Prepared: 4/30/2013 10:17 am
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1.00 Hospital and Hospital Health Care Complex Address:		2.00 PO Box:		3.00 Zip Code: 60612-3714		4.00 County: COOK		1.00
1.00	Street: 1901 WEST HARRISON STREET	2.00 State: IL		3.00 Zip Code: 60612-3714		4.00 County: COOK		2.00
2.00	City: CHI CAGO							

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

3.00 Hospital and Hospital-Based Component Identification:										
3.00	Hospital	JOHN H. STROGER JR. HOSP OF COOK CTY	140124	16974	1	07/01/1966	N	P	O	3.00
4.00	Subprovider - IPF									4.00
5.00	Subprovider - IRF									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									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
18.00	Renal Dialysis	JOHN H. STROGER JR. HOSP DIALYSIS	142313	16794		07/01/1973				18.00
19.00	Other									19.00

						From:	To:			
						1.00	2.00			
20.00	Cost Reporting Period (mm/dd/yyyy)					12/01/2011		11/30/2012		20.00
21.00	Type of Control (see instructions)							9		21.00

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

	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days	
1.00	2.00	3.00	4.00	5.00	6.00		
24.00	45,320	5,380	0	0	1,680	0	24.00
25.00	0	0	0	0	0	0	25.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140124	Period: From 12/01/2011 To 11/30/2012	Worksheet S-2 Part I Date/Time Prepared: 4/30/2013 10:17 am		
		Beginning: 1.00	Ending: 2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0				37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.					38.00
		Y/N 1.00	Y/N 2.00			
39.00	Does the facility potentially qualify for the inpatient hospital adjustment for low volume hospitals as deemed by CMS according to the Federal Register? Enter in column 1 "Y" for yes or "N" for no. Additionally, does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)? Enter in column 2 "Y" for yes or "N" for no.	N	N			39.00
		V 1.00	XVIII 2.00	XIX 3.00		
Prospective Payment System (PPS)-Capital						
45.00	Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions)	N	Y	N		45.00
46.00	Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Worksheet L, Part III and L-1, Parts I through III.	N	N	N		46.00
47.00	Is this a new hospital under 42 CFR §412.300 PPS capital? Enter "Y" for yes or "N" for no.	N	N	N		47.00
48.00	Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no.	N	N	N		48.00
Teaching Hospitals						
56.00	Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no.	Y				56.00
57.00	If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Worksheet D, Part III & IV and D-2, Part II, if applicable.	N				57.00
58.00	If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, section 2148? If yes, complete Worksheet D-5.	Y				58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.	N				59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)	Y				60.00
		Y/N 1.00	IME Average 2.00	Direct GME Average 3.00		
61.00	Did your facility receive additional FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. If "Y", effective for portions of cost reporting periods beginning on or after July 1, 2011 enter the average number of primary care FTE residents for IME in column 2 and direct GME in column 3, from the hospital's three most recent cost reports ending and submitted before March 23, 2010. (see instructions)	N	0.00	0.00		61.00
ACA Provisions Affecting the Health Resources and Services Administration (HRSA)						
62.00	Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions)	0.00				62.00
62.01	Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)	0.00				62.01
Teaching Hospitals that Claim Residents in Non-Provider Settings						
63.00	Has your facility trained residents in non-provider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64-67. (see instructions)	N				63.00
		Unweighted FTEs Nonprovider Site 1.00	Unweighted FTEs in Hospital 2.00	Ratio (col. 1/ (col. 1 + col. 2)) 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 non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)	0.00	0.00	0.000000		64.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA

Provider CCN: 140124

Period:
From 12/01/2011
To 11/30/2012

Worksheet S-2
Part I
Date/Time Prepared:
4/30/2013 10:17 am

		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. Enter in column 2 the program code, enter in column 3 the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4 the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5 the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0.000000	65.00
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1 / (col. 1 + col. 2))	
				1.00	2.00	3.00	
Section 5504 of the ACA Current Year FTE Residents in Nonprovider settings--Effective for cost reporting periods beginning on or after July 1, 2010							
66.00	Enter in column 1 the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all non-provider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)			0.00	0.00	0.000000	66.00
		Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3 / (col. 3 + col. 4))	
		1.00	2.00	3.00	4.00	5.00	
67.00	If line 63 is yes, then, for each primary care residency program in which you are training residents, enter in column 1 the program name. Enter in column 2 the program code. Enter in column 3 the number of unweighted primary care FTE residents attributable to rotations that occurred in nonprovider settings for each applicable program. Enter in column 4 the number of unweighted primary care FTE residents in your hospital for each applicable program. Enter in column 5 the ratio of column 3 divided by the sum of columns 3 and 4. Use subscripted lines 67.01 through 67.50 for each additional primary care program. If you operated a primary care program that did not have FTE residents in a nonprovider setting, enter zero in column 3 and complete all other columns for each applicable program.			0.00	0.00	0.000000	67.00

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

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		Premiums	Losses	Insurance	
		1.00	2.00	3.00	
118.01	List amounts of malpractice premiums and paid losses:	1,082,470	23,140,000		0
			1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N		118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.		N	N	120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.		Y		121.00
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: COOK COUNTY CORPORATE	Contractor's Name:		Contractor's Number: 00131	
142.00	Street: 118 NORTH CLARK STREET	PO Box:			
143.00	City: CHI CAGO	State: IL		Zip Code: 60602	
				1.00	
144.00	Are provider based physicians' costs included in Worksheet A?		Y		144.00
145.00	If costs for renal services are claimed on Worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.		N		145.00
			1.00	2.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.		N		146.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.		N		147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.		N		148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.		N		149.00
		Part A	Part B	Title V	Title XIX
		1.00	2.00	3.00	4.00
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N
156.00	Subprovider - IPF	N	N	N	N
157.00	Subprovider - IRF	N	N	N	N
158.00	SUBPROVIDER				
159.00	SNF	N	N	N	N
160.00	HOME HEALTH AGENCY	N	N	N	N
161.00	CMHC		N	N	N

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		Provider CCN: 140124			Period: From 12/01/2011 To 11/30/2012		Worksheet S-2 Part I Date/Time Prepared: 4/30/2013 10:17 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						0.00	166.00
							1.00	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act								
167.00	Is this provider a meaningful user under Section §1886(n)? Enter "Y" for yes or "N" for no.						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
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)						1.00	169.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 140124	Period: From 12/01/2011 To 11/30/2012	Worksheet S-2 Part II Date/Time Prepared: 4/30/2013 10:17 am	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)		N		1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.		N		2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)		N		3.00
			Y/N	Type	Date
			1.00	2.00	3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.		Y	A	06/15/2013
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.		N		5.00
			Y/N	Legal Oper.	
			1.00	2.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?		N		6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.		N		7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.		N		8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.		Y		9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.		Y		10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.		N		11.00
				Y/N	
				1.00	
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
			Part A		Part B
		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
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)		N		N
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.		Y		N
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
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	CORRECT OUTLIERS	N		N

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 140124	Period: From 12/01/2011 To 11/30/2012	Worksheet S-2 Part II Date/Time Prepared: 4/30/2013 10:17 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			Y	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.			Y	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.			Y	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.	LEO	JANCI LA		41.00
42.00	Enter the employer/company name of the cost report preparer.	COOK COUNTY HEALTH & HOSPITAL SYSTEM			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	312-864-4778	LJANCI LA@COOKCOUNTYHHS.ORG		43.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE

Provider CCN: 140124

Period:
From 12/01/2011
To 11/30/2012

Worksheet S-2
Part II
Date/Time Prepared:
4/30/2013 10:17 am

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

VOLUNTARY CONTACT INFORMATION

Provider CCN: 140124

Period:
From 12/01/2011
To 11/30/2012

Worksheet S-2
Part V
Date/Time Prepared:
4/30/2013 10:17 am

		1.00	
Cost Report Preparer Contact Information			
1.00	First Name		1.00
2.00	Last Name		2.00
3.00	Title		3.00
4.00	Employer	COOK COUNTY HEALTH & HOSPITAL SYSTEM	4.00
5.00	Phone Number		5.00
6.00	E-mail Address		6.00
7.00	Department		7.00
8.00	Mailing Address 1	1900 POLK STREET SUITE 1338	8.00
9.00	Mailing Address 2		9.00
10.00	City	CHI CAGO	10.00
11.00	State		IL 11.00
12.00	Zip	60612	12.00
Officer or Administrator of Provider Contact Information			
13.00	First Name		13.00
14.00	Last Name		14.00
15.00	Title		15.00
16.00	Employer	COOK COUNTY HEALTH & HOSPITAL SYSTEM	16.00
17.00	Phone Number		17.00
18.00	E-mail Address		18.00
19.00	Department		19.00
20.00	Mailing Address 1	1900 POLK STREET	20.00
21.00	Mailing Address 2		21.00
22.00	City	CHI CAGO	22.00
23.00	State		IL 23.00
24.00	Zip	60612	24.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 140124

Period:
From 12/01/2011
To 11/30/2012

Worksheet S-3
Part I
Date/Time Prepared:
4/30/2013 10:17 am

Cost Center Description	Worksheet A	No. of Beds	Bed Days Available	CAH Hours	I/P Days / O/P	
	Line Number				Visits / Trips	Title V
	1.00	2.00	3.00	4.00	5.00	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)	30.00	322	117,852	0.00	0	1.00
2.00 HMO						2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF					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)		322	117,852	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	32	11,712	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT	33.00	8	2,928	0.00	0	10.00
11.00 SURGICAL INTENSIVE CARE UNIT	34.00	14	5,124	0.00	0	11.00
11.01 PEDIATRIC INTENSIVE CARE UNIT	34.01	10	3,660	0.00	0	11.01
11.02 TRAUMA INTENSIVE CARE UNIT	34.02	12	4,392	0.00	0	11.02
11.03 NEURO INTENSIVE CARE UNIT	34.03	10	3,660	0.00	0	11.03
11.04 NEONATAL INTENSIVE CARE UNIT	34.04	52	19,032	0.00	0	11.04
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		460	168,360	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)		460				27.00
28.00 Observation Bed Days					0	28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 140124

Period:
From 12/01/2011
To 11/30/2012

Worksheet S-3
Part I
Date/Time Prepared:
4/30/2013 10:17 am

Cost Center Description	I/P Days / O/P Visits / Trips			Full Time Equivalents		
	Title XVII	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)	9,821	27,057	81,539			1.00
2.00 HMO	750	7,060				2.00
3.00 HMO IPF Subprovider	0	0				3.00
4.00 HMO IRF Subprovider	0	0				4.00
5.00 Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00 Hospital Adults & Peds. Swing Bed NF	0	0	0			6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)	9,821	27,057	81,539			7.00
8.00 INTENSIVE CARE UNIT	1,024	3,684	7,775			8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT	169	543	1,281			10.00
11.00 SURGICAL INTENSIVE CARE UNIT	367	954	2,789			11.00
11.01 PEDIATRIC INTENSIVE CARE UNIT	0	766	1,136			11.01
11.02 TRAUMA INTENSIVE CARE UNIT	378	1,108	2,871			11.02
11.03 NEURO INTENSIVE CARE UNIT	291	168	2,206			11.03
11.04 NEONATAL INTENSIVE CARE UNIT	0	9,369	9,609			11.04
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY		1,671	1,859			13.00
14.00 Total (see instructions)	12,050	45,320	111,065	454.30	4,868.66	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)				454.30	4,868.66	27.00
28.00 Observation Bed Days		0	2,502			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	777			32.00
33.00 LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 140124

Period:
From 12/01/2011
To 11/30/2012

Worksheet S-3
Part I
Date/Time Prepared:
4/30/2013 10:17 am

Cost Center Description	Full Time Equivalents	Discharges			Total All Patients	
	Nonpaid Workers	Title V	Title XVIII	Title XIX		
	11.00	12.00	13.00	14.00		
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)		0	2,564	8,017	23,847	1.00
2.00 HMO			0			2.00
3.00 HMO IPF Subprovider						3.00
4.00 HMO IRF Subprovider						4.00
5.00 Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 Hospital Adults & Peds. Swing Bed NF						6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00 INTENSIVE CARE UNIT						8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
11.01 PEDIATRIC INTENSIVE CARE UNIT						11.01
11.02 TRAUMA INTENSIVE CARE UNIT						11.02
11.03 NEURO INTENSIVE CARE UNIT						11.03
11.04 NEONATAL INTENSIVE CARE UNIT						11.04
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY						13.00
14.00 Total (see instructions)	0.00	0	2,564	8,017	23,847	14.00
15.00 CAH visits						15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF						17.00
18.00 SUBPROVIDER						18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
25.00 CMHC - CMHC						25.00
26.00 RURAL HEALTH CLINIC						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER						26.25
27.00 Total (sum of lines 14-26)	0.00					27.00
28.00 Observation Bed Days						28.00
29.00 Ambulance Trips						29.00
30.00 Employee discount days (see instruction)						30.00
31.00 Employee discount days - IRF						31.00
32.00 Labor & delivery days (see instructions)						32.00
33.00 LTCH non-covered days						33.00

HOSPITAL WAGE INDEX INFORMATION			Provider CCN: 140124	Period: From 12/01/2011 To 11/30/2012	Worksheet S-3 Part II Date/Time Prepared: 4/30/2013 10:17 am			
	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col. 2 ± col. 3)	Paid Hours Related to Salaries in col. 4	Average Hourly Wage (col. 4 ÷ col. 5)		
	1.00	2.00	3.00	4.00	5.00	6.00		
PART II - WAGE DATA								
SALARIES								
1.00	Total salaries (see instructions)	200.00	371,898,784	-2,400,175	369,498,609	9,327,001.00	39.62	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		27,577,582	0	27,577,582	187,599.00	147.00	4.00
4.01	Physicians - Part A - Teaching		17,232,122	0	17,232,122	190,719.00	90.35	4.01
5.00	Physician-Part B		59,323,740	0	59,323,740	565,419.00	104.92	5.00
6.00	Non-physician-Part B		8,187,530	0	8,187,530	155,288.00	52.72	6.00
7.00	Interns & residents (in an approved program)	21.00	21,244,227	-2,321,845	18,922,382	823,589.00	22.98	7.00
7.01	Contracted interns and residents (in an approved programs)		5,228,316	0	5,228,316	355,846.00	14.69	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)		2,451,769	-1,053,242	1,398,527	21,715.00	64.40	10.00
OTHER WAGES & RELATED COSTS								
11.00	Contract labor (see instructions)		9,949,764	0	9,949,764	407,914.00	24.39	11.00
12.00	Contract management and administrative services		0	0	0	0.00	0.00	12.00
13.00	Contract Labor: Physician-Part A - Administrative		0	0	0	0.00	0.00	13.00
14.00	Home office salaries & wage-related costs		44,625,512	0	44,625,512	830,709.00	53.72	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) Wkst S-3, Part IV line 24		75,476,685	0	75,476,685			17.00
18.00	Wage-related costs (other) Wkst S-3, Part IV line 25		0	0	0			18.00
19.00	Excluded areas		310,457	0	310,457			19.00
20.00	Non-physician anesthetist Part A		0	0	0			20.00
21.00	Non-physician anesthetist Part B		2,068,203	0	2,068,203			21.00
22.00	Physician Part A - Administrative		7,254,536	0	7,254,536			22.00
22.01	Physician Part A - Teaching		4,930,416	0	4,930,416			22.01
23.00	Physician Part B		16,483,011	0	16,483,011			23.00
24.00	Wage-related costs (RHC/FOHC)		0	0	0			24.00
25.00	Interns & residents (in an approved program)		15,891,249	0	15,891,249			25.00
OVERHEAD COSTS - DIRECT SALARIES								
26.00	Employee Benefits	4.00	1,643,098	0	1,643,098	36,800.00	44.65	26.00
27.00	Administrative & General	5.00	19,197,318	287,953	19,485,271	747,834.00	26.06	27.00
28.00	Administrative & General under contract (see inst.)		0	0	0	0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	5,869,926	0	5,869,926	134,222.00	43.73	29.00
30.00	Operation of Plant	7.00	9,442,324	0	9,442,324	289,241.00	32.65	30.00
31.00	Laundry & Linen Service	8.00	200,012	0	200,012	8,739.00	22.89	31.00
32.00	Housekeeping	9.00	7,757,611	0	7,757,611	412,013.00	18.83	32.00
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00	33.00
34.00	Dietary	10.00	2,795,497	-7,777	2,787,720	149,035.00	18.71	34.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00	35.00
36.00	Cafeteria	11.00	1,053,641	0	1,053,641	37,253.00	28.28	36.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13.00	3,173,119	0	3,173,119	81,732.00	38.82	38.00
39.00	Central Services and Supply	14.00	1,814,333	0	1,814,333	82,159.00	22.08	39.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00	40.00
41.00	Medical Records & Medical Records Library	16.00	3,566,607	0	3,566,607	157,633.00	22.63	41.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140124

Period:
From 12/01/2011
To 11/30/2012

Worksheet S-3
Part II
Date/Time Prepared:
4/30/2013 10:17 am

		Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
42.00	Soci al Servi ce	17.00	585,559	0	585,559	9,178.00	63.80	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: 140124		Period: From 12/01/2011 To 11/30/2012		Worksheet S-3 Part III Date/Time Prepared: 4/30/2013 10:17 am	
	Worksheet A Line Number	Amount Reported	Recl assi fi cati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col . 2 ± col . 3)	Paid Hours Related to Salaries in col . 4	Average Hourly Wage (col . 4 ÷ col . 5)		
	1.00	2.00	3.00	4.00	5.00	6.00		
PART III - HOSPITAL WAGE INDEX SUMMARY								
1.00	Net salaries (see instructions)	260,682,849	-78,330	260,604,519	7,236,140.00	36.01		1.00
2.00	Excluded area salaries (see instructions)	2,451,769	-1,053,242	1,398,527	21,715.00	64.40		2.00
3.00	Subtotal salaries (line 1 minus line 2)	258,231,080	974,912	259,205,992	7,214,425.00	35.93		3.00
4.00	Subtotal other wages & related costs (see inst.)	54,575,276	0	54,575,276	1,238,623.00	44.06		4.00
5.00	Subtotal wage-related costs (see inst.)	82,731,221	0	82,731,221	0.00	31.92		5.00
6.00	Total (sum of lines 3 thru 5)	395,537,577	974,912	396,512,489	8,453,048.00	46.91		6.00
7.00	Total overhead cost (see instructions)	57,099,045	280,176	57,379,221	2,145,839.00	26.74		7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 140124	Period: From 12/01/2011 To 11/30/2012	Worksheet S-3 Part IV Date/Time Prepared: 4/30/2013 10:17 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)		47,704,269	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)		47,195,194	8.00
9.00	Prescription Drug Plan			0 9.00
10.00	Dental, Hearing and Vision Plan		2,056,960	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		765,949	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)			0 12.00
13.00	Disability Insurance (If employee is owner or beneficiary)			0 13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)			0 14.00
15.00	'Workers' Compensation Insurance		2,135,760	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)			0 16.00
TAXES				
17.00	FICA-Employers Portion Only			0 17.00
18.00	Medicare Taxes - Employers Portion Only		4,842,467	18.00
19.00	Unemployment Insurance		1,151,024	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		26,335	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		105,877,958	24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED - MALPRACTICE EXP		16,536,599	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 140124

Period:
From 12/01/2011
To 11/30/2012

Worksheet S-3
Part V
Date/Time Prepared:
4/30/2013 10:17 am

Cost Center Description		Contract Labor	Benefit Cost	
		1.00	2.00	
PART V - Contract Labor and Benefit Cost				
Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost	0	0	1.00
2.00	Hospital	0	0	2.00
3.00	Subprovider - IPF			3.00
4.00	Subprovider - IRF			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			8.00
9.00	Hospital-Based NF			9.00
10.00	Hospital-Based OLTC			10.00
11.00	Hospital-Based HHA			11.00
12.00	Separately Certified ASC			12.00
13.00	Hospital-Based Hospice			13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospital-Based-CMHC			16.00
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

HOSPITAL RENAL DIALYSIS DEPARTMENT STATISTICAL DATA

Provider CCN: 140124

Period:
From 12/01/2011
To 11/30/2012

Worksheet S-5

Date/Time Prepared:
4/30/2013 10:17 am

		Outpatient		Training		Home		
		Regular	High Flux	Hemodialysis	CAPD / CCPD	Hemodialysis		
		1.00	2.00	3.00	4.00	5.00		
1.00	Number of patients in program at end of cost reporting period	29	0	0	0	0	0	1.00
2.00	Number of times per week patient receives dialysis	3.50	0.00	0.00	0.00	0.00	0.00	2.00
3.00	Average patient dialysis time including setup	5.00	0.00	0.00	0.00	0.00		3.00
4.00	CAPD exchanges per day				0.00			4.00
5.00	Number of days in year dialysis furnished	312	0					5.00
6.00	Number of stations	8	0	0	0			6.00
7.00	Treatment capacity per day per station	4	0					7.00
8.00	Utilization (see instructions)	0.00	0.00					8.00
9.00	Average times dialyzers re-used	0.00	0.00					9.00
10.00	Percentage of patients re-using dialyzers	0.00	0.00					10.00
TRANSPLANT INFORMATION								
11.00	Number of patients on transplant list	0						11.00
12.00	Number of patients transplanted during the cost reporting period	0						12.00
EPOETIN								
13.00	Net costs of Epoetin furnished to all maintenance dialysis patients by the provider.	0						13.00
14.00	Epoetin amount from Worksheet A for Home Dialysis program	0						14.00
15.00	Number of EPO units furnished relating to the renal dialysis department	0						15.00
16.00	Number of EPO units furnished relating to the home dialysis department	0						16.00
ARANESP								
17.00	Net costs of ARANESP furnished to all maintenance dialysis patients by the provider.	0						17.00
18.00	ARANESP amount from Worksheet A for Home Dialysis program	0						18.00
19.00	Number of ARANESP units furnished relating to the renal dialysis department	0						19.00
20.00	Number of ARANESP units furnished relating to the home dialysis department	0						20.00
						MCP	INITIAL METHOD	
						1.00	2.00	
PHYSICIAN PAYMENT METHOD								
21.00	enter "X" if method(s) is applicable						X	21.00

HOSPITAL RENAL DIALYSIS DEPARTMENT STATISTICAL DATA

Provider CCN: 140124

Period:
From 12/01/2011
To 11/30/2012

Worksheet S-5

Date/Time Prepared:
4/30/2013 10:17 am

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

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CCN: 140124	Period: From 12/01/2011 To 11/30/2012	Worksheet S-10 Date/Time Prepared: 4/30/2013 10:17 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)			0.958864	1.00
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid			508,724,397	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			423,615,662	6.00
7.00	Medicaid cost (line 1 times line 6)			406,189,808	7.00
8.00	Difference between net revenue and costs for Medicaid program (line 7 minus sum of lines 2 and 5; if < zero then enter zero)			0	8.00
State Children's Health Insurance Program (SCHIP) (see instructions for each line)					
9.00	Net revenue from stand-alone SCHIP			6,536,748	9.00
10.00	Stand-alone SCHIP charges			6,885,323	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)			6,602,088	11.00
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)			65,340	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)			984,730	13.00
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)			1,930,777	14.00
15.00	State or local indigent care program cost (line 1 times line 14)			1,851,353	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)			866,623	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)			931,963	19.00
		Uninsured patients	Insured patients	Total (col. 1 + col. 2)	
		1.00	2.00	3.00	
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	282,982,842	0	282,982,842	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	271,342,060	0	271,342,060	21.00
22.00	Partial payment by patients approved for charity care	0	0	0	22.00
23.00	Cost of charity care (line 21 minus line 22)	271,342,060	0	271,342,060	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)			333,324,000	26.00
27.00	Medicare bad debts for the entire hospital complex (see instructions)			361,508	27.00
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)			332,962,492	28.00
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)			319,265,747	29.00
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)			590,607,807	30.00
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			591,539,770	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140124

Period:
From 12/01/2011
To 11/30/2012

Worksheet A
Date/Time Prepared:
4/30/2013 10:17 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassification (See A-6)	Reclassified Trial Balance (col. 3 +/- col. 4)	
		1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT		0	18,862,466	18,862,466	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP		0	7,597,206	7,597,206	2.00
3.00	00300	OTHER CAP REL COSTS		0	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS	1,643,098	12,351	1,655,449	101,620,472	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	19,197,318	148,347,524	167,544,842	-102,950,032	5.00
6.00	00600	MAINTENANCE & REPAIRS	5,869,926	0	5,869,926	0	6.00
7.00	00700	OPERATION OF PLANT	9,442,324	17,814,852	27,257,176	0	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	200,012	1,772,878	1,972,890	0	8.00
9.00	00900	HOUSEKEEPING	7,757,611	1,059,407	8,817,018	1,472,969	9.00
10.00	01000	DIETARY	2,795,497	2,366,641	5,162,138	-1,734,102	10.00
11.00	01100	CAFETERIA	1,053,641	0	1,053,641	0	11.00
13.00	01300	NURSING ADMINISTRATION	3,173,119	586,543	3,759,662	0	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,814,333	288,776	2,103,109	0	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	3,566,607	612,256	4,178,863	0	16.00
17.00	01700	SOCIAL SERVICE	585,559	0	585,559	0	17.00
18.00	01850	WAI VER OVERHEAD COSTS	0	0	0	0	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	1,895,274	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	21,244,227	4,833,989	26,078,216	-5,942,628	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	2,269,078	477,286	2,746,364	25,698,426	22.00
23.00	02300	ALLIED HEALTH	0	0	0	220,667	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	65,433,850	9,818,998	75,252,848	-8,786,472	30.00
31.00	03100	INTENSIVE CARE UNIT	8,446,440	52,904	8,499,344	-5,880	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	2,295,572	8,332	2,303,904	-66,306	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	3,495,142	34,335	3,529,477	2,523	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	2,606,446	1,353	2,607,799	-51,791	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	7,370,879	737,734	8,108,613	-112,475	34.02
34.03	02060	NEURO INTENSIVE CARE UNIT	3,847,476	12,210	3,859,686	-647,906	34.03
34.04	02061	NEONATAL INTENSIVE CARE UNIT	10,721,908	47,658	10,769,566	-300,240	34.04
43.00	04300	NURSERY	2,321,886	7,362	2,329,248	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	30,680,786	136,436	30,817,222	-2,994,220	50.00
51.00	05100	RECOVERY ROOM	2,417,320	1,255	2,418,575	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	3,517,578	19,205	3,536,783	954	52.00
53.00	05300	ANESTHESIOLOGY	10,019,458	39,302	10,058,760	-4,898,062	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	15,530,197	7,961,668	23,491,865	-569,627	54.00
60.00	06000	LABORATORY	16,316,403	5,052,978	21,369,381	-256,263	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,033,505	3,986,589	5,020,094	0	62.00
64.00	06400	INTRAVENOUS THERAPY	813,669	0	813,669	0	64.00
65.00	06500	RESPIRATORY THERAPY	6,569,855	668,114	7,237,969	-88,873	65.00
66.00	06600	PHYSICAL THERAPY	1,481,233	5,493	1,486,726	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	440,593	750	441,343	0	67.00
68.00	06800	SPEECH PATHOLOGY	417,531	137,018	554,549	0	68.00
69.00	06900	ELECTROCARDIOLOGY	5,278,217	185,988	5,464,205	-79,215	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	29,737,181	29,737,181	-4,244,548	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	4,244,548	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	47,821	41,185,302	41,233,123	-280,023	73.00
74.00	07400	RENAL DIALYSIS	2,926,283	263,266	3,189,549	0	74.00
76.00	03950	WAI VER PURCHASED PATIENT SERVICES	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	57,364,309	37,131,357	94,495,666	-27,289,556	90.00
91.00	09100	EMERGENCY	27,440,308	137,065	27,577,373	-1,616,398	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS							
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE		0	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	369,447,015	315,542,356	684,989,371	-1,299,112	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
190.01	19001	DENTISTRY	51,594	67,755	119,349	482,902	190.01
190.02	19002	ACHN SATELLITE CLINICS	0	0	0	0	190.02
190.03	19003	SPECIAL FUNDS	0	0	0	816,210	190.03
190.04	19004	SENGSTACKE CLINIC	2,400,175	172,137	2,572,312	0	190.04
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	777,686	777,686	0	194.00
200.00		TOTAL (SUM OF LINES 118-199)	371,898,784	316,559,934	688,458,718	0	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140124

Period:
From 12/01/2011
To 11/30/2012

Worksheet A
Date/Time Prepared:
4/30/2013 10:17 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	29,763,932	48,626,398	1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP	94,513	7,691,719	2.00
3.00	00300	OTHER CAP REL COSTS	0	0	3.00
4.00	00400	EMPLOYEE BENEFITS	10,009,221	113,285,142	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	76,102,488	140,697,298	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	5,869,926	6.00
7.00	00700	OPERATION OF PLANT	-2,821,810	24,435,366	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	1,972,890	8.00
9.00	00900	HOUSEKEEPING	0	10,289,987	9.00
10.00	01000	DIETARY	0	3,428,036	10.00
11.00	01100	CAFETERIA	0	1,053,641	11.00
13.00	01300	NURSING ADMINISTRATION	0	3,759,662	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	2,103,109	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	-89,848	4,089,015	16.00
17.00	01700	SOCIAL SERVICE	0	585,559	17.00
18.00	01850	WAIVER OVERHEAD COSTS	0	0	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	-1,895,274	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	20,135,588	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	-9,008,249	19,436,541	22.00
23.00	02300	ALLIED HEALTH	0	220,667	23.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-28,615,698	37,850,678	30.00
31.00	03100	INTENSIVE CARE UNIT	-255,129	8,238,335	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	-675,174	1,562,424	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	-164,058	3,367,942	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	-732,078	1,823,930	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	-2,012,457	5,983,681	34.02
34.03	02060	NEURO INTENSIVE CARE UNIT	-1,093,290	2,118,490	34.03
34.04	02061	NEONATAL INTENSIVE CARE UNIT	-3,453,300	7,016,026	34.04
43.00	04300	NURSERY	0	2,329,248	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-12,201,791	15,621,211	50.00
51.00	05100	RECOVERY ROOM	0	2,418,575	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	-116,524	3,421,213	52.00
53.00	05300	ANESTHESIOLOGY	-4,587,315	573,383	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-7,641,743	15,280,495	54.00
60.00	06000	LABORATORY	-4,566,617	16,546,501	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	5,020,094	62.00
64.00	06400	INTRAVENOUS THERAPY	0	813,669	64.00
65.00	06500	RESPIRATORY THERAPY	-2,147,178	5,001,918	65.00
66.00	06600	PHYSICAL THERAPY	0	1,486,726	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	441,343	67.00
68.00	06800	SPEECH PATHOLOGY	0	554,549	68.00
69.00	06900	ELECTROCARDIOLOGY	-2,348,769	3,036,221	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	25,492,633	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	4,244,548	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	30,128,616	71,081,716	73.00
74.00	07400	RENAL DIALYSIS	0	3,189,549	74.00
76.00	03950	WAIVER PURCHASED PATIENT SERVICES	0	0	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	-24,111,787	43,094,323	90.00
91.00	09100	EMERGENCY	-4,494,285	21,466,690	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			92.00
OTHER REIMBURSABLE COST CENTERS					
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	98.00
SPECIAL PURPOSE COST CENTERS					
113.00	11300	INTEREST EXPENSE	0	0	113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	33,066,396	716,756,655	118.00
NONREIMBURSABLE COST CENTERS					
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00
190.01	19001	DENTISTRY	0	602,251	190.01
190.02	19002	ACHN SATELLITE CLINICS	0	0	190.02
190.03	19003	SPECIAL FUNDS	0	816,210	190.03
190.04	19004	SENGSTACKE CLINIC	-2,572,312	0	190.04
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	777,686	194.00
200.00		TOTAL (SUM OF LINES 118-199)	30,494,084	718,952,802	200.00

RECLASSIFICATIONS

Provider CCN: 140124

Period:
From 12/01/2011
To 11/30/2012

Worksheet A-6
Date/Time Prepared:
4/30/2013 10:17 am

		Increases			
Cost Center		Line #	Salary	Other	
2.00		3.00	4.00	5.00	
A - TO RECLASS FRINGE BENEFITS TO EHW					
1.00	EMPLOYEE BENEFITS	4.00	0	101,620,472	1.00
2.00		0.00	0	0	2.00
	TOTALS		0	101,620,472	
B - SERVICE CONTRACTS					
1.00	HOUSEKEEPING	9.00	0	1,472,969	1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	253,356	2.00
	TOTALS		0	1,726,325	
C - SAL OF NON RESIDENTS MOVED TO OTHER					
1.00	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	774,564	0	1.00
	TOTALS		774,564	0	
D - TRANSFER MOONLIGHTING TO ER					
1.00	EMERGENCY	91.00	1,620,720	0	1.00
	TOTALS		1,620,720	0	
E - TO RECLASSIFY I/R OTHER COST					
1.00	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	0	8,179,558	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
	TOTALS		0	8,179,558	
F - TO ALLOCATE PEDS ALGY & PSYCH TO INP					
1.00	ADULTS & PEDIATRICS	30.00	300,967	27,486	1.00
	TOTALS		300,967	27,486	
G - TO TRANSFER DIETARY SAL TO CLINIC					
1.00	CLINIC	90.00	7,777	0	1.00
	TOTALS		7,777	0	
H - TO ALLOCATE REGISTRY AND IN-HOUSE NSG					
1.00	INTENSIVE CARE UNIT	31.00	0	95,311	1.00
2.00	BURN INTENSIVE CARE UNIT	33.00	0	36,217	2.00
3.00	SURGICAL INTENSIVE CARE UNIT	34.00	0	25,912	3.00
4.00	PEDIATRIC INTENSIVE CARE UNIT	34.01	0	701	4.00
5.00	TRAUMA INTENSIVE CARE UNIT	34.02	0	86,299	5.00
6.00	NEURO INTENSIVE CARE UNIT	34.03	0	18,880	6.00
7.00	DELIVERY ROOM & LABOR ROOM	52.00	0	954	7.00
8.00	EMERGENCY	91.00	0	195,417	8.00
	TOTALS		0	459,691	
I - TO RECLASS NON-PHY ANESTH TO PRP GRP					
1.00	NONPHYSICIAN ANESTHETISTS	19.00	1,895,274	0	1.00
	TOTALS		1,895,274	0	
J - TO RECLASS HEKTOEN COST TO RESRCH.					
1.00	SPECIAL FUNDS	190.03	816,210	0	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
	TOTALS		816,210	0	
K - TO RECLASS COST OF IMPLANTS					
1.00	IMPL. DEV. CHARGED TO PATIENTS	72.00	0	4,244,548	1.00
	TOTALS		0	4,244,548	
M - TO RECLASS HBP TEACHING TIME					
1.00	I&R SERVICES-OTHER PRGM COSTS APPRV	22.00	17,036,071	0	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4.00
5.00		0.00	0	0	5.00
6.00		0.00	0	0	6.00
7.00		0.00	0	0	7.00
8.00		0.00	0	0	8.00
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
	TOTALS		17,036,071	0	

RECLASSIFICATIONS

Provider CCN: 140124

Period:
From 12/01/2011
To 11/30/2012

Worksheet A-6

Date/Time Prepared:
4/30/2013 10:17 am

		Increases				
Cost Center		Line #	Salary	Other		
2.00	3.00	4.00	5.00			
N - DEPRECIATION RECLASS						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	18,862,466	1.00	
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	7,597,206	2.00	
	TOTALS		0	26,459,672		
O - SENGSTACKE CLINIC						
1.00	SENGSTACKE CLINIC	190.04	0	2,400,175	1.00	
	TOTALS		0	2,400,175		
P - PODIATRY RESIDENTS						
1.00	I&R SERVICES-SALARY & FRINGES APPRV	21.00	73,439	0	1.00	
	TOTALS		73,439	0		
Q - INSURANCE RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	2,462,089	1.00	
	TOTALS		0	2,462,089		
R - PHARMACY SCHOOL						
1.00	ALLIED HEALTH	23.00	47,821	172,846	1.00	
	TOTALS		47,821	172,846		
S - MEDICAL DIRECTOR						
1.00	ADMINISTRATIVE & GENERAL	5.00	291,767	0	1.00	
	TOTALS		291,767	0		
T - DENTISTRY PHYSICIANS						
1.00	DENTISTRY	190.01	482,902	0	1.00	
	TOTALS		482,902	0		
500.00	Grand Total: Increases		23,347,512	147,752,862	500.00	

RECLASSIFICATIONS

Provider CCN: 140124

Period:
From 12/01/2011
To 11/30/2012

Worksheet A-6
Date/Time Prepared:
4/30/2013 10:17 am

		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7.00	8.00	9.00	10.00		
A - TO RECLASS FRINGE BENEFITS TO EHW							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	79,840,380	0		1.00
2.00	CLINIC	90.00	0	21,780,092	0		2.00
	TOTALS		0	101,620,472			
B - SERVICE CONTRACTS							
1.00	DIETARY	10.00	0	1,726,325	0		1.00
2.00		0.00	0	0	0		2.00
	TOTALS		0	1,726,325			
C - SAL OF NON RESIDENTS MOVED TO OTHER							
1.00	I&R SERVICES-SALARY & FRINGES APPRV	21.00	774,564	0	0		1.00
	TOTALS		774,564	0			
D - TRANSFER MOONLIGHTING TO ER							
1.00	I&R SERVICES-SALARY & FRINGES APPRV	21.00	1,620,720	0	0		1.00
	TOTALS		1,620,720	0			
E - TO RECLASSIFY I/R OTHER COST							
1.00	I&R SERVICES-SALARY & FRINGES APPRV	21.00	0	3,620,783	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	3,976,886	0		2.00
3.00	LABORATORY	60.00	0	19,240	0		3.00
4.00	ADMINISTRATIVE & GENERAL	5.00	0	503,293	0		4.00
5.00	DRUGS CHARGED TO PATIENTS	73.00	0	59,356	0		5.00
	TOTALS		0	8,179,558			
F - TO ALLOCATE PEDS ALGY & PSYCH TO INP							
1.00	CLINIC	90.00	300,967	27,486	0		1.00
	TOTALS		300,967	27,486			
G - TO TRANSFER DIETARY SAL TO CLINIC							
1.00	DIETARY	10.00	7,777	0	0		1.00
	TOTALS		7,777	0			
H - TO ALLOCATE REGISTRY AND IN-HOUSE NSG							
1.00	ADULTS & PEDIATRICS	30.00	0	459,691	0		1.00
2.00		0.00	0	0	0		2.00
3.00		0.00	0	0	0		3.00
4.00		0.00	0	0	0		4.00
5.00		0.00	0	0	0		5.00
6.00		0.00	0	0	0		6.00
7.00		0.00	0	0	0		7.00
8.00		0.00	0	0	0		8.00
	TOTALS		0	459,691			
I - TO RECLASS NON-PHY ANESTH TO PRP GRP							
1.00	ANESTHESIOLOGY	53.00	1,895,274	0	0		1.00
	TOTALS		1,895,274	0			
J - TO RECLASS HEKTOEN COST TO RESRCH.							
1.00	ADMINISTRATIVE & GENERAL	5.00	3,814	0	0		1.00
2.00	ADULTS & PEDIATRICS	30.00	755,349	0	0		2.00
3.00	ANESTHESIOLOGY	53.00	14,224	0	0		3.00
4.00	CLINIC	90.00	42,823	0	0		4.00
	TOTALS		816,210	0			
K - TO RECLASS COST OF IMPLANTS							
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	4,244,548	0		1.00
	TOTALS		0	4,244,548			
M - TO RECLASS HBP TEACHING TIME							
1.00	ADULTS & PEDIATRICS	30.00	3,922,999	0	0		1.00
2.00	INTENSIVE CARE UNIT	31.00	101,191	0	0		2.00
3.00	BURN INTENSIVE CARE UNIT	33.00	102,523	0	0		3.00
4.00	PEDIATRIC INTENSIVE CARE UNIT	34.01	52,492	0	0		4.00
5.00	TRAUMA INTENSIVE CARE UNIT	34.02	198,774	0	0		5.00
6.00	NEURO INTENSIVE CARE UNIT	34.03	666,786	0	0		6.00
7.00	NEONATAL INTENSIVE CARE UNIT	34.04	300,240	0	0		7.00
8.00	OPERATING ROOM	50.00	2,437,879	0	0		8.00
9.00	ANESTHESIOLOGY	53.00	2,988,564	0	0		9.00
10.00	RADIOLOGY-DIAGNOSTIC	54.00	569,627	0	0		10.00
11.00	LABORATORY	60.00	237,023	0	0		11.00
12.00	RESPIRATORY THERAPY	65.00	88,873	0	0		12.00
13.00	ELECTROCARDIOLOGY	69.00	79,215	0	0		13.00
14.00	CLINIC	90.00	1,833,961	0	0		14.00
15.00	EMERGENCY	91.00	3,432,535	0	0		15.00
16.00	SURGICAL INTENSIVE CARE UNIT	34.00	23,389	0	0		16.00
	TOTALS		17,036,071	0			

RECLASSIFICATIONS

Provider CCN: 140124

Period:
From 12/01/2011
To 11/30/2012

Worksheet A-6
Date/Time Prepared:
4/30/2013 10:17 am

Decreases								
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.			
	6.00	7.00	8.00	9.00	10.00			
	N - DEPRECIATION RECLASS							
1.00	ADMINISTRATIVE & GENERAL	5.00	0	25,609,757		9	1.00	
2.00	CLINIC	90.00	0	849,915		9	2.00	
	TOTALS		0	26,459,672				
	O - SENGSTACKE CLINIC							
1.00	SENGSTACKE CLINIC	190.04	2,400,175	0		0	1.00	
	TOTALS		2,400,175	0				
	P - PODIATRY RESIDENTS							
1.00	OPERATING ROOM	50.00	73,439	0		0	1.00	
	TOTALS		73,439	0				
	Q - INSURANCE RECLASS							
1.00	CLINIC	90.00	0	2,462,089		0	1.00	
	TOTALS		0	2,462,089				
	R - PHARMACY SCHOOL							
1.00	DRUGS CHARGED TO PATIENTS	73.00	47,821	172,846		0	1.00	
	TOTALS		47,821	172,846				
	S - MEDICAL DIRECTOR							
1.00	I&R SERVICES-OTHER PRGM	22.00	291,767	0		0	1.00	
	COSTS APPRV							
	TOTALS		291,767	0				
	T - DENTISTRY PHYSICIANS							
1.00	OPERATING ROOM	50.00	482,902	0		0	1.00	
	TOTALS		482,902	0				
500.00	Grand Total: Decreases			25,747,687	145,352,687		500.00	

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140124

Period:
From 12/01/2011
To 11/30/2012

Worksheet A-7
Parts I-III
Date/Time Prepared:
4/30/2013 10:17 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
			1.00	2.00	3.00		
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	0	0	0	0	0	1.00
2.00	Land Improvements	2,717,512	0	0	0	0	2.00
3.00	Buildings and Fixtures	522,106,130	163,848	0	163,848	0	3.00
4.00	Building Improvements	81,971,430	3,786,851	0	3,786,851	0	4.00
5.00	Fixed Equipment	151,069,483	1,182,430	0	1,182,430	0	5.00
6.00	Movable Equipment	12,194,070	1,930,402	0	1,930,402	0	6.00
7.00	HIT designated Assets	0	4,436,718	0	4,436,718	0	7.00
8.00	Subtotal (sum of lines 1-7)	770,058,625	11,500,249	0	11,500,249	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	770,058,625	11,500,249	0	11,500,249	0	10.00
SUMMARY OF CAPITAL							
Cost Center Description		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	0	0	0	0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	0	0	3.00
COMPUTATION OF RATIOS					ALLOCATION OF OTHER CAPITAL		
Cost Center Description		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	767,434,402	0	767,434,402	0.981928	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	14,124,472	0	14,124,472	0.018072	0	2.00
3.00	Total (sum of lines 1-2)	781,558,874	0	781,558,874	1.000000	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140124

Period:
From 12/01/2011
To 11/30/2012

Worksheet A-7
Parts I-III
Date/Time Prepared:
4/30/2013 10:17 am

		Ending Balance	Fully Depreciated Assets				
		6.00	7.00				
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	0	0		1.00		
2.00	Land Improvements	2,717,512	0		2.00		
3.00	Buildings and Fixtures	522,269,978	0		3.00		
4.00	Building Improvements	85,758,281	0		4.00		
5.00	Fixed Equipment	152,251,913	0		5.00		
6.00	Movable Equipment	14,124,472	0		6.00		
7.00	HIT designated Assets	4,436,718	0		7.00		
8.00	Subtotal (sum of lines 1-7)	781,558,874	0		8.00		
9.00	Reconciling Items	0	0		9.00		
10.00	Total (line 8 minus line 9)	781,558,874	0		10.00		
SUMMARY OF CAPITAL							
Cost Center Description		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	0		1.00		
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		2.00		
3.00	Total (sum of lines 1-2)	0	0		3.00		
ALLOCATION OF OTHER CAPITAL							
Cost Center Description		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	15,802,710	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	7,691,719	0	2.00
3.00	Total (sum of lines 1-2)	0	0	0	23,494,429	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140124

Period:
From 12/01/2011
To 11/30/2012

Worksheet A-7
Parts I-III
Date/Time Prepared:
4/30/2013 10:17 am

Cost Center Description	SUMMARY OF CAPITAL					Total (2) (sum of cols. 9 through 14)	
	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)			
	11.00	12.00	13.00	14.00	15.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FIXT	32,823,688	0	0	0	48,626,398	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	0	7,691,719	2.00
3.00	Total (sum of lines 1-2)	32,823,688	0	0	0	56,318,117	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 140124

Period:
From 12/01/2011
To 11/30/2012

Worksheet A-8
Date/Time Prepared:
4/30/2013 10:17 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted			
			Cost Center		Line #	
			1.00	2.00	3.00	4.00
1.00 Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			OCAP REL COSTS-BLDG & FIXT		1.00	1.00
2.00 Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)			OCAP REL COSTS-MVBLE EQUIP		2.00	2.00
3.00 Investment income - other (chapter 2)		0			0.00	3.00
4.00 Trade, quantity, and time discounts (chapter 8)		0			0.00	4.00
5.00 Refunds and rebates of expenses (chapter 8)		0			0.00	5.00
6.00 Rental of provider space by suppliers (chapter 8)		0			0.00	6.00
7.00 Telephone services (pay stations excluded) (chapter 21)		0			0.00	7.00
8.00 Television and radio service (chapter 21)		0			0.00	8.00
9.00 Parking lot (chapter 21)	B	-2,938,046	OPERATION OF PLANT		7.00	9.00
10.00 Provider-based physician adjustment	A-8-2	-97,810,803				10.00
11.00 Sale of scrap, waste, etc. (chapter 23)	B	-42,842	ADMINISTRATIVE & GENERAL		5.00	11.00
12.00 Related organization transactions (chapter 10)	A-8-1	531,716				12.00
13.00 Laundry and linen service		0			0.00	13.00
14.00 Cafeteria-employees and guests		0			0.00	14.00
15.00 Rental of quarters to employee and others		0			0.00	15.00
16.00 Sale of medical and surgical supplies to other than patients	B	-364,443	LABORATORY		60.00	16.00
17.00 Sale of drugs to other than patients	B	-112	DRUGS CHARGED TO PATIENTS		73.00	17.00
18.00 Sale of medical records and abstracts	B	-89,848	MEDICAL RECORDS & LIBRARY		16.00	18.00
19.00 Nursing school (tuition, fees, books, etc.)		0			0.00	19.00
20.00 Vending machines		0			0.00	20.00
21.00 Income from imposition of interest, finance or penalty charges (chapter 21)		0			0.00	21.00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments		0			0.00	22.00
23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14)	A-8-3		ORESPIRATORY THERAPY		65.00	23.00
24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14)	A-8-3		OPHYSICAL 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	A	-2,328,584	CAP REL COSTS-BLDG & FIXT		1.00	26.00
27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP	A	94,513	CAP REL COSTS-MVBLE EQUIP		2.00	27.00
28.00 Non-physician Anesthetist	A	-1,895,274	NONPHYSICIAN ANESTHETISTS		19.00	28.00
29.00 Physicians' assistant		0			0.00	29.00
30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3		OCCUPATIONAL THERAPY		67.00	30.00
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3		OSPEECH PATHOLOGY		68.00	31.00
32.00 CAH HIT Adjustment for Depreciation and Interest		0			0.00	32.00
33.00 OTHER ADJUSTMENTS (SPECIFY) (3)		0			0.00	33.00
33.01 MISCELLANEOUS INCOME	B	-499,179	ADMINISTRATIVE & GENERAL		5.00	33.01
33.02 OTHER INCOME	B	-1,975,194	ADMINISTRATIVE & GENERAL		5.00	33.02
33.03		0			0.00	33.03
33.04 COUNTY ADJ. FOR HOSPITAL BOND INT.	A	32,823,688	CAP REL COSTS-BLDG & FIXT		1.00	33.04
33.05		0			0.00	33.05
33.06 SYSTEM HEALTH & HOSPITAL ADMINSTN.	A	79,359,964	ADMINISTRATIVE & GENERAL		5.00	33.06
33.07 SYSTEM HEALTH & HOSPITAL PHARMCY.	A	29,263,059	DRUGS CHARGED TO PATIENTS		73.00	33.07
33.08 SYSTEM HEALTH & HOSPITAL BENEFITS	A	8,808,410	EMPLOYEE BENEFITS		4.00	33.08
33.09 SYSTEM HEALTH & HOSPITAL BENEFITS	A	116,236	OPERATION OF PLANT		7.00	33.09
33.10 RESIDENCY PROGRAM REIMBURSEMNT.	B	-390,018	I&R SERVICES-OTHER PRGM COSTS APPRV		22.00	33.10
33.11		0			0.00	33.11
33.12 TO OFFSET PHYSICIAN PART C TIME	A	-42,004	I&R SERVICES-OTHER PRGM COSTS APPRV		22.00	33.12
33.13 TO OFFSET PHYSICIAN PART C TIME	A	-970,676	ADULTS & PEDIATRICS		30.00	33.13
33.14 TO OFFSET PHYSICIAN PART C TIME	A	-103	INTENSIVE CARE UNIT		31.00	33.14
33.15 TO OFFSET PHYSICIAN PART C TIME	A	-5,682	PEDIATRIC INTENSIVE CARE UNIT		34.01	33.15
33.16 TO OFFSET PHYSICIAN PART C TIME	A	-33,389	TRAUMA INTENSIVE CARE UNIT		34.02	33.16
33.17 TO OFFSET PHYSICIAN PART C TIME	A	-79,291	NEONATAL INTENSIVE CARE UNIT		34.04	33.17
33.18 TO OFFSET PHYSICIAN PART C TIME	A	-260,678	OPERATING ROOM		50.00	33.18

ADJUSTMENTS TO EXPENSES

Provider CCN: 140124

Period:
From 12/01/2011
To 11/30/2012

Worksheet A-8

Date/Time Prepared:
4/30/2013 10:17 am

Cost Center Description	Basis/Code (2)	Amount	Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted	
			Cost Center	Line #
			1.00	2.00
33.19 TO OFFSET PHYSICIAN PART C TIME	A	-7,734	ANESTHESIOLOGY	53.00 33.19
33.20 TO OFFSET PHYSICIAN PART C TIME	A	-51,000	RADIOLOGY-DIAGNOSTIC	54.00 33.20
33.21 TO OFFSET PHYSICIAN PART C TIME	A	-74,128	LABORATORY	60.00 33.21
33.22 TO OFFSET PHYSICIAN PART C TIME	A	-5,433	RESPIRATORY THERAPY	65.00 33.22
33.23 TO OFFSET PHYSICIAN PART C TIME	A	-10,803	ELECTROCARDIOLOGY	69.00 33.23
33.24 TO OFFSET PHYSICIAN PART C TIME	A	-303,142	CLINIC	90.00 33.24
33.25		0		0.00 33.25
33.26 TO OFFSET PHYSICIAN PART C TIME	A	-304,144	EMERGENCY	91.00 33.26
33.27 MALPRACTICE EXPENSE	A	395,633	ADMINISTRATIVE & GENERAL	5.00 33.27
33.28 PROPERTY TAX ACCRUAL	A	-860,733	ADMINISTRATIVE & GENERAL	5.00 33.28
33.29 PROPERTY TAX ACCRUAL	A	-719,568	CLINIC	90.00 33.29
33.30 TO REMOVE SENGSTACKE CLINIC FROM C/R	A	-2,572,312	SENGSTACKE CLINIC	190.04 33.30
33.31 IHA LOBBYING	A	-106,213	ADMINISTRATIVE & GENERAL	5.00 33.31
33.32		0		0.00 33.32
33.33 NURSE PRACTITIONER AND PHYS ASST.	A	-1,773,397	ADULTS & PEDIATRICS	30.00 33.33
33.34 NURSE PRACTITIONER AND PHYS ASST.	A	-90,286	SURGICAL INTENSIVE CARE UNIT	34.00 33.34
33.35 NURSE PRACTITIONER AND PHYS ASST.	A	-125,009	PEDIATRIC INTENSIVE CARE UNIT	34.01 33.35
33.36 NURSE PRACTITIONER AND PHYS ASST.	A	-331,156	NEURO INTENSIVE CARE UNIT	34.03 33.36
33.37 NURSE PRACTITIONER AND PHYS ASST.	A	-457,147	NEONATAL INTENSIVE CARE UNIT	34.04 33.37
33.38 NURSE PRACTITIONER AND PHYS ASST.	A	-857,008	OPERATING ROOM	50.00 33.38
33.39 NURSE PRACTITIONER AND PHYS ASST.	A	-116,524	DELIVERY ROOM & LABOR ROOM	52.00 33.39
33.40 NURSE PRACTITIONER AND PHYS ASST.	A	-125,472	ELECTROCARDIOLOGY	69.00 33.40
33.41		0		0.00 33.41
33.42 NURSE PRACTITIONER AND PHYS ASST.	A	-1,424,155	CLINIC	90.00 33.42
33.43 NURSE PRACTITIONER AND PHYS ASST.	A	-992,102	EMERGENCY	91.00 33.43
33.44 OAK FOREST VACANT SPACE ADJUSTMENT	A	-731,172	CAP REL COSTS-BLDG & FIXT	1.00 33.44
33.45 PHARMACY ADJUSTMENT	A	865,669	DRUGS CHARGED TO PATIENTS	73.00 33.45
33.46		0		0.00 33.46
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		30,494,084		50.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 140124

Period:
From 12/01/2011
To 11/30/2012

Worksheet A-8

Date/Time Prepared:
4/30/2013 10:17 am

Cost Center Description		Wkst. A-7 Ref.	
		5.00	
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)	0	2.00
3.00	Investment income - other (chapter 2)	0	3.00
4.00	Trade, quantity, and time discounts (chapter 8)	0	4.00
5.00	Refunds and rebates of expenses (chapter 8)	0	5.00
6.00	Rental of provider space by suppliers (chapter 8)	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)	0	7.00
8.00	Television and radio service (chapter 21)	0	8.00
9.00	Parking lot (chapter 21)	0	9.00
10.00	Provider-based physician adjustment	0	10.00
11.00	Sale of scrap, waste, etc. (chapter 23)	0	11.00
12.00	Related organization transactions (chapter 10)	0	12.00
13.00	Laundry and linen service	0	13.00
14.00	Cafeteria-employees and guests	0	14.00
15.00	Rental of quarters to employee and others	0	15.00
16.00	Sale of medical and surgical supplies to other than patients	0	16.00
17.00	Sale of drugs to other than patients	0	17.00
18.00	Sale of medical records and abstracts	0	18.00
19.00	Nursing school (tuition, fees, books, etc.)	0	19.00
20.00	Vending machines	0	20.00
21.00	Income from imposition of interest, finance or penalty charges (chapter 21)	0	21.00
22.00	Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments	0	22.00
23.00	Adjustment for respiratory therapy costs in excess of limitation (chapter 14)		23.00
24.00	Adjustment for physical therapy costs in excess of limitation (chapter 14)		24.00
25.00	Utilization review - physicians' compensation (chapter 21)		25.00
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT	9	26.00
27.00	Depreciation - CAP REL COSTS-MVBLE EQUIP	9	27.00
28.00	Non-physician Anesthetist		28.00
29.00	Physicians' assistant	0	29.00
30.00	Adjustment for occupational therapy costs in excess of limitation (chapter 14)		30.00
31.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)		31.00
32.00	CAH HIT Adjustment for Depreciation and Interest	0	32.00
33.00	OTHER ADJUSTMENTS (SPECIFY) (3)	0	33.00
33.01	MISCELLANEOUS INCOME	0	33.01
33.02	OTHER INCOME	0	33.02
33.03		0	33.03
33.04	COUNTY ADJ. FOR HOSPITAL BOND INT.	11	33.04
33.05		0	33.05
33.06	SYSTEM HEALTH & HOSPITAL ADMINSTN.	0	33.06
33.07	SYSTEM HEALTH & HOSPITAL PHARMCY.	0	33.07
33.08	SYSTEM HEALTH & HOSPITAL BENEFITS	0	33.08
33.09	SYSTEM HEALTH & HOSPITAL BENEFITS	0	33.09
33.10	RESIDENCY PROGRAM REIMBURSEMNT.	0	33.10
33.11		0	33.11
33.12	TO OFFSET PHYSICIAN PART C TIME	0	33.12
33.13	TO OFFSET PHYSICIAN PART C TIME	0	33.13
33.14	TO OFFSET PHYSICIAN PART C TIME	0	33.14
33.15	TO OFFSET PHYSICIAN PART C TIME	0	33.15
33.16	TO OFFSET PHYSICIAN PART C TIME	0	33.16
33.17	TO OFFSET PHYSICIAN PART C TIME	0	33.17
33.18	TO OFFSET PHYSICIAN PART C TIME	0	33.18
33.19	TO OFFSET PHYSICIAN PART C TIME	0	33.19
33.20	TO OFFSET PHYSICIAN PART C TIME	0	33.20
33.21	TO OFFSET PHYSICIAN PART C TIME	0	33.21
33.22	TO OFFSET PHYSICIAN PART C TIME	0	33.22
33.23	TO OFFSET PHYSICIAN PART C TIME	0	33.23
33.24	TO OFFSET PHYSICIAN PART C TIME	0	33.24
33.25		0	33.25
33.26	TO OFFSET PHYSICIAN PART C TIME	0	33.26
33.27	MALPRACTICE EXPENSE	0	33.27

ADJUSTMENTS TO EXPENSES

Provider CCN: 140124

Period:
From 12/01/2011
To 11/30/2012

Worksheet A-8

Date/Time Prepared:
4/30/2013 10:17 am

Cost Center Description		Wkst. A-7 Ref.	
		5.00	
33.28	PROPERTY TAX ACCRUAL	0	33.28
33.29	PROPERTY TAX ACCRUAL	0	33.29
33.30	TO REMOVE SENGSTACKE CLINIC FROM C/R	0	33.30
33.31	IHA LOBBYING	0	33.31
33.32		0	33.32
33.33	NURSE PRACTITIONER AND PHYS ASST.	0	33.33
33.34	NURSE PRACTITIONER AND PHYS ASST.	0	33.34
33.35	NURSE PRACTITIONER AND PHYS ASST.	0	33.35
33.36	NURSE PRACTITIONER AND PHYS ASST.	0	33.36
33.37	NURSE PRACTITIONER AND PHYS ASST.	0	33.37
33.38	NURSE PRACTITIONER AND PHYS ASST.	0	33.38
33.39	NURSE PRACTITIONER AND PHYS ASST.	0	33.39
33.40	NURSE PRACTITIONER AND PHYS ASST.	0	33.40
33.41		0	33.41
33.42	NURSE PRACTITIONER AND PHYS ASST.	0	33.42
33.43	NURSE PRACTITIONER AND PHYS ASST.	0	33.43
33.44	OAK FOREST VACANT SPACE ADJUSTMENT	9	33.44
33.45	PHARMACY ADJUSTMENT	0	33.45
33.46		0	33.46
50.00	TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		50.00

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

Provider CCN: 140124

Period:
From 12/01/2011
To 11/30/2012

Worksheet A-8-1

Date/Time Prepared:
4/30/2013 10:17 am

	Line No.	Cost Center	Expense Items	
	1.00	2.00	3.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:				
1.00		5.00ADMINISTRATIVE & GENERAL	STORE ROOM	1.00
2.00		5.00ADMINISTRATIVE & GENERAL	PAYROLL	2.00
3.00		5.00ADMINISTRATIVE & GENERAL	GENERAL ACCOUNTING	3.00
3.01		90.00CLINIC	0	3.01
4.00		5.00ADMINISTRATIVE & GENERAL	COUNTY COSTS ALLOCATED TO CCHHS	4.00
4.01		4.00EMPLOYEE BENEFITS	COUNTY COSTS ALLOCATED TO CCHHS	4.01
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.			5.00

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

	Symbol (1)	Name	Percentage of Ownership	
	1.00	2.00	3.00	
B. 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	O.F, PROV &	100.00	6.00
7.00		G	SPECIAL FUNDS	100.00	7.00
8.00		G	COOK CTY GOVNMT	100.00	8.00
9.00				0.00	9.00
10.00				0.00	10.00
100.00	G. Other (financial or non-financial) specify:		GVRNMNT AGENCY		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: 140124

Period: From 12/01/2011 To 11/30/2012

Worksheet A-8-1

Date/Time Prepared: 4/30/2013 10:17 am

	Amount of Allowable Cost	Amount Included in Wks. A, column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	1,599,445	1,614,288	-14,843	0	1.00
2.00	178,316	179,956	-1,640	0	2.00
3.00	423,549	424,205	-656	0	3.00
3.01	0	500,147	-500,147	0	3.01
4.00	2,175,458	2,327,267	-151,809	0	4.00
4.01	1,200,811	0	1,200,811	0	4.01
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.	5,577,579	5,045,863	531,716	5.00

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

Related Organization(s) and/or Home Office			
Name	Percentage of Ownership	Type of Business	
4.00	5.00	6.00	

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

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

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

6.00	OUTRCH CLINICS	100.00	NOT HOSP BASED	6.00
7.00	OUTRCH CLINICS	100.00	GOVRNMNT AGENCY	7.00
8.00	BUDGET, COMPTLR	100.00	TREAS, ST ATRNY	8.00
9.00		0.00		9.00
10.00		0.00		10.00
100.00	G. Other (financial or non-financial) specify:			100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 140124

Period:
From 12/01/2011
To 11/30/2012

Worksheet A-8-2

Date/Time Prepared:
4/30/2013 10:17 am

		Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
		1.00	2.00	3.00	4.00	
1.00		22.00	I&R SERVICES-OTHER PRGM COSTS APPRV	22,938,185	33,922	1.00
2.00		30.00	ADULTS & PEDIATRICS	34,237,616	21,680,717	2.00
3.00		31.00	INTENSIVE CARE UNIT	614,823	49,730	3.00
4.00		33.00	BURN INTENSIVE CARE UNIT	807,672	510,695	4.00
5.00		34.00	SURGICAL INTENSIVE CARE UNIT	88,083	56,995	5.00
6.00		34.01	PEDIATRIC INTENSIVE CARE UNIT	835,210	497,857	6.00
7.00		34.02	TRAUMA INTENSIVE CARE UNIT	2,200,963	1,852,539	7.00
8.00		34.03	NEURO INTENSIVE CARE UNIT	854,923	693,728	8.00
9.00		34.04	NEONATAL INTENSIVE CARE UNIT	3,696,490	2,660,398	9.00
10.00		50.00	OPERATING ROOM	13,634,713	9,574,254	10.00
11.00		53.00	ANESTHESIOLOGY	6,534,363	3,275,264	11.00
12.00		54.00	RADIOLOGY-DIAGNOSTIC	8,231,689	7,195,322	12.00
13.00		60.00	LABORATORY	5,701,375	3,789,866	13.00
14.00		65.00	RESPIRATORY THERAPY	2,926,256	1,918,255	14.00
15.00		69.00	ELECTROCARDIOLOGY	2,530,873	1,903,517	15.00
16.00		90.00	CLINIC	24,358,654	19,721,835	16.00
18.00		91.00	EMERGENCY	6,083,307	1,300,993	18.00
200.00				136,275,195	76,715,887	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 140124

Period:
From 12/01/2011
To 11/30/2012

Worksheet A-8-2

Date/Time Prepared:
4/30/2013 10:17 am

	Provider Component	RCE Amount	Physician/Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	5.00	6.00	7.00	8.00	9.00	
1.00	22,904,263	177,200	152,923	13,027,863	651,393	1.00
2.00	12,556,899	177,200	89,616	7,634,594	381,730	2.00
3.00	565,093	177,200	3,837	326,883	16,344	3.00
4.00	296,977	208,000	1,152	115,200	5,760	4.00
5.00	31,088	208,000	125	12,500	625	5.00
6.00	337,353	177,200	2,514	214,173	10,709	6.00
7.00	348,423	208,000	2,016	201,600	10,080	7.00
8.00	161,195	208,000	834	83,400	4,170	8.00
9.00	1,036,092	177,200	8,443	719,279	35,964	9.00
10.00	4,060,459	208,000	23,141	2,314,100	115,705	10.00
11.00	3,259,099	200,300	18,328	1,764,951	88,248	11.00
12.00	1,036,366	225,300	5,360	580,581	29,029	12.00
13.00	1,911,509	215,700	14,098	1,461,990	73,100	13.00
14.00	1,008,001	200,300	7,537	725,799	36,290	14.00
15.00	627,356	165,600	3,540	281,838	14,092	15.00
16.00	4,636,819	177,200	34,320	2,923,800	146,190	16.00
18.00	4,782,314	177,200	30,598	2,606,714	130,336	18.00
200.00	59,559,306		398,382	34,995,265	1,749,765	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 140124

Period:
From 12/01/2011
To 11/30/2012

Worksheet A-8-2

Date/Time Prepared:
4/30/2013 10:17 am

	Cost of Memberships & Continuing Education	Provider Component Share of col. 12	Physician Cost of Malpractice Insurance	Provider Component Share of col. 14	Adjusted RCE Limit	
	12.00	13.00	14.00	15.00	16.00	
1.00	0	0	1,336,071	1,334,095	14,361,958	1.00
2.00	0	0	1,994,225	731,397	8,365,991	2.00
3.00	0	0	35,811	32,914	359,797	3.00
4.00	0	0	47,044	17,298	132,498	4.00
5.00	0	0	5,131	1,811	14,311	5.00
6.00	0	0	48,648	19,650	233,823	6.00
7.00	0	0	128,199	20,295	221,895	7.00
8.00	0	0	49,796	9,389	92,789	8.00
9.00	0	0	215,308	60,349	779,628	9.00
10.00	0	0	794,176	236,508	2,550,608	10.00
11.00	0	0	380,604	189,831	1,954,782	11.00
12.00	0	0	479,468	60,365	640,946	12.00
13.00	0	0	332,086	111,339	1,573,329	13.00
14.00	0	0	170,444	58,712	784,511	14.00
15.00	0	0	147,415	36,541	318,379	15.00
16.00	0	0	1,418,809	270,079	3,193,879	16.00
18.00	0	0	354,332	278,554	2,885,268	18.00
200.00	0	0	7,937,567	3,469,127	38,464,392	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 140124

Period:
From 12/01/2011
To 11/30/2012

Worksheet A-8-2
Date/Time Prepared:
4/30/2013 10:17 am

	RCE	Adjustment	
	Disallowance		
	17.00	18.00	
1.00	8,542,305	8,576,227	1.00
2.00	4,190,908	25,871,625	2.00
3.00	205,296	255,026	3.00
4.00	164,479	675,174	4.00
5.00	16,777	73,772	5.00
6.00	103,530	601,387	6.00
7.00	126,528	1,979,068	7.00
8.00	68,406	762,134	8.00
9.00	256,464	2,916,862	9.00
10.00	1,509,851	11,084,105	10.00
11.00	1,304,317	4,579,581	11.00
12.00	395,420	7,590,743	12.00
13.00	338,180	4,128,046	13.00
14.00	223,490	2,141,745	14.00
15.00	308,977	2,212,494	15.00
16.00	1,442,940	21,164,775	16.00
18.00	1,897,046	3,198,039	18.00
200.00	21,094,914	97,810,803	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140124

Period:
From 12/01/2011
To 11/30/2012

Worksheet B
Part I
Date/Time Prepared:
4/30/2013 10:17 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		BLDG & FIXT	MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	48,626,398	48,626,398			1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP	7,691,719		7,691,719		2.00
4.00 00400	EMPLOYEE BENEFITS	113,285,142	393,423	13,809	113,692,374	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	140,697,298	7,356,846	481,424	154,498,395	5.00
6.00 00600	MAINTENANCE & REPAIRS	5,869,926	1,473,029	23,189	9,189,748	6.00
7.00 00700	OPERATION OF PLANT	24,435,366	15,912,118	20,078	43,300,999	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	1,972,890	360,932	185	2,396,145	8.00
9.00 00900	HOUSEKEEPING	10,289,987	380,554	7,485	13,088,075	9.00
10.00 01000	DIETARY	3,428,036	20,734	520	4,315,348	10.00
11.00 01100	CAFETERIA	1,053,641	866,279	27,898	2,275,152	11.00
13.00 01300	NURSING ADMINISTRATION	3,759,662	232,455	105,986	5,083,893	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	2,103,109	1,317,435	116,071	4,100,272	14.00
16.00 01600	MEDICAL RECORDS & LIBRARY	4,089,015	613,894	3,164	5,814,107	16.00
17.00 01700	SOCIAL SERVICE	585,559	74,493	182	842,149	17.00
18.00 01850	WAIVER OVERHEAD COSTS	0	0	0	0	18.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	20,135,588	21,392	1,935	26,037,512	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	19,436,541	0	0	25,674,685	22.00
23.00 02300	ALLIED HEALTH	220,667	2,574	0	238,098	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	37,850,678	5,547,901	3,257,377	65,624,183	30.00
31.00 03100	INTENSIVE CARE UNIT	8,238,335	577,554	4,819	11,413,318	31.00
33.00 03300	BURN INTENSIVE CARE UNIT	1,562,424	123,289	1,571	2,368,596	33.00
34.00 03400	SURGICAL INTENSIVE CARE UNIT	3,367,942	194,261	0	4,640,769	34.00
34.01 02080	PEDIATRIC INTENSIVE CARE UNIT	1,823,930	136,858	1,643	2,755,865	34.01
34.02 02180	TRAUMA INTENSIVE CARE UNIT	5,983,681	467,050	51,247	8,730,129	34.02
34.03 02060	NEURO INTENSIVE CARE UNIT	2,118,490	97,594	0	3,204,226	34.03
34.04 02061	NEONATAL INTENSIVE CARE UNIT	7,016,026	248,864	27,263	10,529,842	34.04
43.00 04300	NURSERY	2,329,248	178,037	0	3,228,623	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	15,621,211	1,425,014	1,045,244	26,842,849	50.00
51.00 05100	RECOVERY ROOM	2,418,575	274,972	928	3,445,461	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	3,421,213	272,439	0	4,786,454	52.00
53.00 05300	ANESTHESIOLOGY	573,383	95,020	145,142	2,404,604	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	15,280,495	1,713,101	584,496	22,225,877	54.00
60.00 06000	LABORATORY	16,546,501	1,583,882	180,239	23,305,987	60.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELL	5,020,094	56,786	422	5,398,380	62.00
64.00 06400	INTRAVENOUS THERAPY	813,669	203,938	0	1,270,389	64.00
65.00 06500	RESPIRATORY THERAPY	5,001,918	113,407	255,088	7,383,853	65.00
66.00 06600	PHYSICAL THERAPY	1,486,726	94,650	8,576	2,050,125	66.00
67.00 06700	OCCUPATIONAL THERAPY	441,343	91,293	0	669,515	67.00
68.00 06800	SPEECH PATHOLOGY	554,549	46,594	15,185	746,042	68.00
69.00 06900	ELECTROCARDIOLOGY	3,036,221	437,093	326,152	5,414,635	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	25,492,633	0	0	25,492,633	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	4,244,548	0	0	4,244,548	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	71,081,716	236,428	629,258	71,947,402	73.00
74.00 07400	RENAL DIALYSIS	3,189,549	47,891	16,295	4,162,840	74.00
76.00 03950	WAIVER PURCHASED PATIENT SERVICES	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	43,094,323	3,468,370	224,742	63,934,604	90.00
91.00 09100	EMERGENCY	21,466,690	1,468,993	112,908	31,010,569	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)				0	92.00
OTHER REIMBURSABLE COST CENTERS						
98.00 05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	716,756,655	48,227,437	7,690,521	716,086,896	118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
190.01 19001	DENTISTRY	602,251	93,558	1,198	713,036	190.01
190.02 19002	ACHN SATELLITE CLINICS	0	0	0	0	190.02
190.03 19003	SPECIAL FUNDS	816,210	305,403	0	1,375,184	190.03
190.04 19004	SENGSTACKE CLINIC	0	0	0	0	190.04
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	777,686	0	0	777,686	194.00
200.00	Cross Foot Adjustments				0	200.00
201.00	Negative Cost Centers		0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	718,952,802	48,626,398	7,691,719	718,952,802	202.00

COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 140124	Period: From 12/01/2011 To 11/30/2012	Worksheet B Part I Date/Time Prepared: 4/30/2013 10:17 am				
Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING		
		5.00	6.00	7.00	8.00	9.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00		
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00		
4.00	00400	EMPLOYEE BENEFITS				4.00		
5.00	00500	ADMINISTRATIVE & GENERAL	154,498,395			5.00		
6.00	00600	MAINTENANCE & REPAIRS	2,515,353	11,705,101		6.00		
7.00	00700	OPERATION OF PLANT	11,852,046	4,726,858	59,879,903	7.00		
8.00	00800	LAUNDRY & LINEN SERVICE	655,856	107,219	920,038	4,079,258	8.00	
9.00	00900	HOUSEKEEPING	3,582,376	113,048	970,055	128,889	17,882,443	9.00
10.00	01000	DIETARY	1,181,167	6,159	52,851	31,036	16,298	10.00
11.00	01100	CAFETERIA	622,739	257,337	2,208,197	0	680,946	11.00
13.00	01300	NURSING ADMINISTRATION	1,391,528	69,053	592,540	0	182,723	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	1,122,298	391,358	3,358,219	34,230	1,035,581	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	1,591,397	182,364	1,564,852	0	482,557	16.00
17.00	01700	SOCIAL SERVICE	230,507	22,129	189,886	0	58,556	17.00
18.00	01850	WAIVER OVERHEAD COSTS	0	0	0	0	0	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	7,126,806	6,355	54,531	0	16,816	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	7,027,495	0	0	0	0	22.00
23.00	02300	ALLIED HEALTH	65,171	765	6,560	0	2,023	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	17,962,192	1,648,062	14,141,928	1,345,845	4,360,976	30.00
31.00	03100	INTENSIVE CARE UNIT	3,123,974	171,568	1,472,219	0	453,991	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	648,316	36,624	314,272	112,673	96,913	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	1,270,239	57,707	495,183	0	152,701	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	754,316	40,655	348,859	0	107,578	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	2,389,550	138,742	1,190,539	195,938	367,129	34.02
34.03	02060	NEURO INTENSIVE CARE UNIT	877,038	28,991	248,772	17,117	76,715	34.03
34.04	02061	NEONATAL INTENSIVE CARE UNIT	2,882,155	73,928	634,370	155,592	195,622	34.04
43.00	04300	NURSERY	883,716	52,888	453,826	0	139,947	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	7,347,237	423,315	3,632,446	420,971	1,120,145	50.00
51.00	05100	RECOVERY ROOM	943,067	81,683	700,919	142,533	216,144	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1,310,115	80,931	694,464	223,209	214,153	52.00
53.00	05300	ANESTHESIOLOGY	658,171	28,227	242,212	16,187	74,691	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	6,083,511	508,895	4,366,797	477,541	1,346,599	54.00
60.00	06000	LABORATORY	6,379,152	470,509	4,037,409	0	1,245,025	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1,477,607	16,869	144,750	0	44,637	62.00
64.00	06400	INTRAVENOUS THERAPY	347,722	60,582	519,851	0	160,307	64.00
65.00	06500	RESPIRATORY THERAPY	2,021,057	33,689	289,080	0	89,144	65.00
66.00	06600	PHYSICAL THERAPY	561,146	28,117	241,267	33,582	74,400	66.00
67.00	06700	OCCUPATIONAL THERAPY	183,255	27,120	232,712	0	71,762	67.00
68.00	06800	SPEECH PATHOLOGY	204,201	13,841	118,770	0	36,626	68.00
69.00	06900	ELECTROCARDIOLOGY	1,482,056	129,843	1,114,175	75,514	343,581	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	6,977,665	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1,161,788	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	19,692,823	70,233	602,670	0	185,847	73.00
74.00	07400	RENAL DIALYSIS	1,139,423	14,227	122,077	0	37,645	74.00
76.00	03950	WAIVER PURCHASED PATIENT SERVICES	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	17,499,732	1,030,315	8,841,080	118,501	2,726,343	90.00
91.00	09100	EMERGENCY	8,487,996	436,380	3,744,551	549,900	1,154,715	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	153,713,959	11,586,586	58,862,927	4,079,258	17,568,836	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	DENTISTRY	195,167	27,792	238,486	0	73,542	190.01
190.02	19002	ACHN SATELITTE CLINICS	0	0	0	0	0	190.02
190.03	19003	SPECIAL FUNDS	376,406	90,723	778,490	0	240,065	190.03
190.04	19004	SENGSTACKE CLINIC	0	0	0	0	0	190.04
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	212,863	0	0	0	0	194.00
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)	154,498,395	11,705,101	59,879,903	4,079,258	17,882,443	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140124

Period:
From 12/01/2011
To 11/30/2012

Worksheet B
Part I
Date/Time Prepared:
4/30/2013 10:17 am

Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	
		10.00	11.00	13.00	14.00	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
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000	5,602,859					10.00
11.00	01100		6,044,371				11.00
13.00	01300		62,726	7,382,463			13.00
14.00	01400		62,475	118,473	10,222,906		14.00
16.00	01600		119,443	0	1,567	9,756,287	16.00
17.00	01700		6,950	3,549	0	0	17.00
18.00	01850		0	0	0	0	18.00
19.00	01900		0	0	0	0	19.00
21.00	02100		625,095	0	3,053	0	21.00
22.00	02200		144,421	0	4,415	0	22.00
23.00	02300		4,048	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	4,642,718	988,884	1,646,359	27,614	2,387,347	30.00
31.00	03100	142,328	141,753	313,349	16,852	225,476	31.00
33.00	03300	32,553	29,527	57,071	2,748	37,155	33.00
34.00	03400	33,135	58,898	128,809	11,323	80,902	34.00
34.01	02080	21,257	40,400	79,856	0	32,960	34.01
34.02	02180	29,700	118,517	231,735	22,050	83,299	34.02
34.03	02060	51,231	48,496	99,251	4,028	63,972	34.03
34.04	02061	0	151,543	283,700	112	278,661	34.04
43.00	04300	0	345	106,146	2,333	53,934	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	440,290	765,464	33,521	0	50.00
51.00	05100	0	42,926	97,098	0	0	51.00
52.00	05200	0	62,553	141,479	6,216	0	52.00
53.00	05300	0	55,901	90,741	11,110	0	53.00
54.00	05400	0	247,296	0	10,445	0	54.00
60.00	06000	0	366,943	0	0	0	60.00
62.00	06200	0	25,793	0	265	0	62.00
64.00	06400	0	13,744	31,101	0	0	64.00
65.00	06500	0	121,906	234,361	84,964	0	65.00
66.00	06600	0	29,261	0	498	0	66.00
67.00	06700	0	10,920	0	10	0	67.00
68.00	06800	0	9,790	0	38	0	68.00
69.00	06900	0	94,058	44,546	4,912	0	69.00
71.00	07100	0	0	0	9,805,355	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	0	361,640	0	3,574	0	73.00
74.00	07400	0	44,291	75,525	66,380	60,601	74.00
76.00	03950	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	159,170	1,022,916	1,917,610	59,579	3,505,812	90.00
91.00	09100	490,767	481,632	916,240	39,944	2,946,168	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
98.00	05950	0	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		5,602,859	6,035,381	7,382,463	10,222,906	9,756,287	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
190.01	19001	0	1,349	0	0	0	190.01
190.02	19002	0	0	0	0	0	190.02
190.03	19003	0	7,641	0	0	0	190.03
190.04	19004	0	0	0	0	0	190.04
194.00	07950	0	0	0	0	0	194.00
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		5,602,859	6,044,371	7,382,463	10,222,906	9,756,287	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140124

Period:
From 12/01/2011
To 11/30/2012

Worksheet B
Part I
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Cost Center Description	SOCIAL SERVICE	OTHER GENERAL SERVICE		NONPHYSICIAN ANESTHETISTS	INTERNS & RESIDENTS		
		WAI VER OVERHEAD COSTS			SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV	
		17.00	18.00				
GENERAL SERVICE COST CENTERS							
1.00 00100 CAP REL COSTS-BLDG & FIXT							1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP							2.00
4.00 00400 EMPLOYEE BENEFITS							4.00
5.00 00500 ADMINISTRATIVE & GENERAL							5.00
6.00 00600 MAINTENANCE & REPAIRS							6.00
7.00 00700 OPERATION OF PLANT							7.00
8.00 00800 LAUNDRY & LINEN SERVICE							8.00
9.00 00900 HOUSEKEEPING							9.00
10.00 01000 DIETARY							10.00
11.00 01100 CAFETERIA							11.00
13.00 01300 NURSING ADMINISTRATION							13.00
14.00 01400 CENTRAL SERVICES & SUPPLY							14.00
16.00 01600 MEDICAL RECORDS & LIBRARY							16.00
17.00 01700 SOCIAL SERVICE	1,353,726						17.00
18.00 01850 WAI VER OVERHEAD COSTS	0	0					18.00
19.00 01900 NONPHYSICIAN ANESTHETISTS	0	0	0				19.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	33,870,168			21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	32,851,016		22.00
23.00 02300 ALLIED HEALTH	0	0	0	0	0		23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000 ADULTS & PEDIATRICS	409,637	0	0	10,142,810	9,837,612		30.00
31.00 03100 INTENSIVE CARE UNIT	33,409	0	0	1,271,589	1,233,327		31.00
33.00 03300 BURN INTENSIVE CARE UNIT	16,632	0	0	272,110	263,922		33.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	25,069	0	0	351,350	340,778		34.00
34.01 02080 PEDIATRIC INTENSIVE CARE UNIT	16,632	0	0	149,511	145,012		34.01
34.02 02180 TRAUMA INTENSIVE CARE UNIT	25,069	0	0	0	0		34.02
34.03 02060 NEURO INTENSIVE CARE UNIT	25,069	0	0	182,403	176,915		34.03
34.04 02061 NEONATAL INTENSIVE CARE UNIT	25,069	0	0	684,759	664,155		34.04
43.00 04300 NURSERY	0	0	0	221,276	214,618		43.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	0	0	0	4,701,366	4,559,902		50.00
51.00 05100 RECOVERY ROOM	0	0	0	0	0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	287,808	279,148		52.00
53.00 05300 ANESTHESIOLOGY	0	0	0	1,935,417	1,877,180		53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	1,273,084	1,234,777		54.00
60.00 06000 LABORATORY	0	0	0	141,288	137,036		60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0		62.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0	82,978	80,482		64.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	717,652	696,058		65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	0	0		66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	22,427	21,752		67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	0		68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	1,054,051	1,022,335		69.00
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	50,138	0	0	0	0		74.00
76.00 03950 WAI VER PURCHASED PATIENT SERVICES	0	0	0	0	0		76.00
OUTPATIENT SERVICE COST CENTERS							
90.00 09000 CLINIC	476,312	0	0	4,861,342	4,715,065		90.00
91.00 09100 EMERGENCY	250,690	0	0	5,516,947	5,350,942		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART							92.00
OTHER REIMBURSABLE COST CENTERS							
98.00 05950 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0		98.00
SPECIAL PURPOSE COST CENTERS							
113.00 11300 INTEREST EXPENSE							113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	1,353,726	0	0	33,870,168	32,851,016	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0		190.00
190.01 19001 DENTISTRY	0	0	0	0	0		190.01
190.02 19002 ACHN SATELLITE CLINICS	0	0	0	0	0		190.02
190.03 19003 SPECIAL FUNDS	0	0	0	0	0		190.03
190.04 19004 SENGSTACKE CLINIC	0	0	0	0	0		190.04
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0		194.00
200.00	Cross Foot Adjustments			0	0		200.00
201.00	Negative Cost Centers	0	0	0	0		201.00
202.00	TOTAL (sum lines 118-201)	1,353,726	0	0	33,870,168	32,851,016	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140124

Period:
From 12/01/2011
To 11/30/2012

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description			ALLIED HEALTH	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
			23.00	24.00	25.00	26.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.00	00500	ADMINISTRATIVE & GENERAL					5.00
6.00	00600	MAINTENANCE & REPAIRS					6.00
7.00	00700	OPERATION OF PLANT					7.00
8.00	00800	LAUNDRY & LINEN SERVICE					8.00
9.00	00900	HOUSEKEEPING					9.00
10.00	01000	DIETARY					10.00
11.00	01100	CAFETERIA					11.00
13.00	01300	NURSING ADMINISTRATION					13.00
14.00	01400	CENTRAL SERVICES & SUPPLY					14.00
16.00	01600	MEDICAL RECORDS & LIBRARY					16.00
17.00	01700	SOCIAL SERVICE					17.00
18.00	01850	WAIVER OVERHEAD COSTS					18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS					19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV					21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV					22.00
23.00	02300	ALLIED HEALTH	316,665				23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	0	135,166,167	-19,980,422	115,185,745	30.00
31.00	03100	INTENSIVE CARE UNIT	0	20,013,153	-2,504,916	17,508,237	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	4,289,112	-536,032	3,753,080	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	7,646,863	-692,128	6,954,735	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	0	4,492,901	-294,523	4,198,378	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	0	13,522,397	0	13,522,397	34.02
34.03	02060	NEURO INTENSIVE CARE UNIT	0	5,104,224	-359,318	4,744,906	34.03
34.04	02061	NEONATAL INTENSIVE CARE UNIT	0	16,559,508	-1,348,914	15,210,594	34.04
43.00	04300	NURSERY	0	5,357,652	-435,894	4,921,758	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	50,287,506	-9,261,268	41,026,238	50.00
51.00	05100	RECOVERY ROOM	0	5,669,831	0	5,669,831	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	8,086,530	-566,956	7,519,574	52.00
53.00	05300	ANESTHESIOLOGY	0	7,394,441	-3,812,597	3,581,844	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	37,774,822	-2,507,861	35,266,961	54.00
60.00	06000	LABORATORY	0	36,083,349	-278,324	35,805,025	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	7,108,301	0	7,108,301	62.00
64.00	06400	INTRAVENOUS THERAPY	0	2,567,156	-163,460	2,403,696	64.00
65.00	06500	RESPIRATORY THERAPY	0	11,671,764	-1,413,710	10,258,054	65.00
66.00	06600	PHYSICAL THERAPY	0	3,018,396	0	3,018,396	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,239,473	-44,179	1,195,294	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,129,308	0	1,129,308	68.00
69.00	06900	ELECTROCARDIOLOGY	0	10,779,706	-2,076,386	8,703,320	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	42,275,653	0	42,275,653	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,406,336	0	5,406,336	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	316,665	93,180,854	0	93,180,854	73.00
74.00	07400	RENAL DIALYSIS	0	5,773,147	0	5,773,147	74.00
76.00	03950	WAIVER PURCHASED PATIENT SERVICES	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	110,868,381	-9,576,407	101,291,974	90.00
91.00	09100	EMERGENCY	0	61,377,441	-10,867,889	50,509,552	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0		92.00
OTHER REIMBURSABLE COST CENTERS							
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	316,665	713,844,372	-66,721,184	647,123,188	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
190.01	19001	DENTISTRY	0	1,249,372	0	1,249,372	190.01
190.02	19002	ACHN SATELITE CLINICS	0	0	0	0	190.02
190.03	19003	SPECIAL FUNDS	0	2,868,509	0	2,868,509	190.03
190.04	19004	SENGSTACKE CLINIC	0	0	0	0	190.04
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	990,549	0	990,549	194.00
200.00		Cross Foot Adjustments	0	0	0	0	200.00
201.00		Negative Cost Centers	0	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	316,665	718,952,802	-66,721,184	652,231,618	202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140124	Period: From 12/01/2011 To 11/30/2012	Worksheet B Part II Date/Time Prepared: 4/30/2013 10:17 am	
Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS
		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	142,446	393,423	13,809	549,678
5.00 00500	ADMINISTRATIVE & GENERAL	7,825,069	7,356,846	481,424	15,663,339
6.00 00600	MAINTENANCE & REPAIRS	0	1,473,029	23,189	1,496,218
7.00 00700	OPERATION OF PLANT	4,620	15,912,118	20,078	15,936,816
8.00 00800	LAUNDRY & LINEN SERVICE	0	360,932	185	361,117
9.00 00900	HOUSEKEEPING	0	380,554	7,485	388,039
10.00 01000	DIETARY	0	20,734	520	21,254
11.00 01100	CAFETERIA	0	866,279	27,898	894,177
13.00 01300	NURSING ADMINISTRATION	410,362	232,455	105,986	748,803
14.00 01400	CENTRAL SERVICES & SUPPLY	0	1,317,435	116,071	1,433,506
16.00 01600	MEDICAL RECORDS & LIBRARY	0	613,894	3,164	617,058
17.00 01700	SOCIAL SERVICE	0	74,493	182	74,675
18.00 01850	WAIVER OVERHEAD COSTS	0	0	0	0
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0	21,392	1,935	23,327
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0
23.00 02300	ALLIED HEALTH	0	2,574	0	2,574
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00 03000	ADULTS & PEDIATRICS	26,595	5,547,901	3,257,377	8,831,873
31.00 03100	INTENSIVE CARE UNIT	0	577,554	4,819	582,373
33.00 03300	BURN INTENSIVE CARE UNIT	0	123,289	1,571	124,860
34.00 03400	SURGICAL INTENSIVE CARE UNIT	0	194,261	0	194,261
34.01 02080	PEDIATRIC INTENSIVE CARE UNIT	0	136,858	1,643	138,501
34.02 02180	TRAUMA INTENSIVE CARE UNIT	0	467,050	51,247	518,297
34.03 02060	NEURO INTENSIVE CARE UNIT	0	97,594	0	97,594
34.04 02061	NEONATAL INTENSIVE CARE UNIT	0	248,864	27,263	276,127
43.00 04300	NURSERY	0	178,037	0	178,037
ANCILLARY SERVICE COST CENTERS					
50.00 05000	OPERATING ROOM	0	1,425,014	1,045,244	2,470,258
51.00 05100	RECOVERY ROOM	0	274,972	928	275,900
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	272,439	0	272,439
53.00 05300	ANESTHESIOLOGY	0	95,020	145,142	240,162
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	1,713,101	584,496	2,297,597
60.00 06000	LABORATORY	0	1,583,882	180,239	1,764,121
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	56,786	422	57,208
64.00 06400	INTRAVENOUS THERAPY	0	203,938	0	203,938
65.00 06500	RESPIRATORY THERAPY	358,631	113,407	255,088	727,126
66.00 06600	PHYSICAL THERAPY	0	94,650	8,576	103,226
67.00 06700	OCCUPATIONAL THERAPY	0	91,293	0	91,293
68.00 06800	SPEECH PATHOLOGY	0	46,594	15,185	61,779
69.00 06900	ELECTROCARDIOLOGY	0	437,093	326,152	763,245
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0
73.00 07300	DRUGS CHARGED TO PATIENTS	0	236,428	629,258	865,686
74.00 07400	RENAL DIALYSIS	0	47,891	16,295	64,186
76.00 03950	WAIVER PURCHASED PATIENT SERVICES	0	0	0	0
OUTPATIENT SERVICE COST CENTERS					
90.00 09000	CLINIC	1,076,883	3,468,370	224,742	4,769,995
91.00 09100	EMERGENCY	0	1,468,993	112,908	1,581,901
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART				0
OTHER REIMBURSABLE COST CENTERS					
98.00 05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0
SPECIAL PURPOSE COST CENTERS					
113.00 11300	INTEREST EXPENSE				113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	9,844,606	48,227,437	7,690,521	65,762,564
NONREIMBURSABLE COST CENTERS					
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0
190.01 19001	DENTISTRY	0	93,558	1,198	94,756
190.02 19002	ACHN SATELITE CLINICS	0	0	0	0
190.03 19003	SPECIAL FUNDS	0	305,403	0	305,403
190.04 19004	SENGSTACKE CLINIC	0	0	0	0
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0
200.00	Cross Foot Adjustments				200.00
201.00	Negative Cost Centers				0
202.00	TOTAL (sum lines 118-201)	9,844,606	48,626,398	7,691,719	66,162,723

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140124	Period: From 12/01/2011 To 11/30/2012	Worksheet B Part II Date/Time Prepared: 4/30/2013 10:17 am				
Cost Center Description		ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING		
		5.00	6.00	7.00	8.00	9.00		
GENERAL SERVICE COST CENTERS								
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00		
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00		
4.00	00400	EMPLOYEE BENEFITS				4.00		
5.00	00500	ADMINISTRATIVE & GENERAL	15,692,168			5.00		
6.00	00600	MAINTENANCE & REPAIRS	255,484	1,760,519		6.00		
7.00	00700	OPERATION OF PLANT	1,203,811	710,947	17,865,756	7.00		
8.00	00800	LAUNDRY & LINEN SERVICE	66,615	16,126	274,502	718,660	8.00	
9.00	00900	HOUSEKEEPING	363,862	17,003	289,425	22,707	1,092,688	9.00
10.00	01000	DIETARY	119,971	926	15,769	5,468	996	10.00
11.00	01100	CAFETERIA	63,252	38,705	658,837	0	41,609	11.00
13.00	01300	NURSING ADMINISTRATION	141,337	10,386	176,790	0	11,165	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	113,992	58,863	1,001,957	6,030	63,278	14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	161,638	27,429	466,889	0	29,486	16.00
17.00	01700	SOCIAL SERVICE	23,413	3,328	56,654	0	3,578	17.00
18.00	01850	WAIVER OVERHEAD COSTS	0	0	0	0	0	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	723,869	956	16,270	0	1,028	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	713,782	0	0	0	0	22.00
23.00	02300	ALLIED HEALTH	6,619	115	1,957	0	124	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	1,824,418	247,879	4,219,386	237,104	266,472	30.00
31.00	03100	INTENSIVE CARE UNIT	317,302	25,805	439,251	0	27,741	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	65,849	5,509	93,766	19,850	5,922	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	129,018	8,680	147,743	0	9,331	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	76,616	6,115	104,085	0	6,573	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	242,706	20,868	355,209	34,519	22,433	34.02
34.03	02060	NEURO INTENSIVE CARE UNIT	89,081	4,360	74,224	3,015	4,688	34.03
34.04	02061	NEONATAL INTENSIVE CARE UNIT	292,740	11,119	189,270	27,411	11,953	34.04
43.00	04300	NURSERY	89,759	7,955	135,403	0	8,551	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	746,258	63,669	1,083,776	74,164	68,445	50.00
51.00	05100	RECOVERY ROOM	95,787	12,286	209,126	25,111	13,207	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	133,068	12,173	207,200	39,324	13,086	52.00
53.00	05300	ANESTHESIOLOGY	66,850	4,245	72,266	2,852	4,564	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	617,902	76,541	1,302,877	84,130	82,283	54.00
60.00	06000	LABORATORY	647,930	70,767	1,204,601	0	76,076	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	150,080	2,537	43,188	0	2,727	62.00
64.00	06400	INTRAVENOUS THERAPY	35,318	9,112	155,102	0	9,795	64.00
65.00	06500	RESPIRATORY THERAPY	205,278	5,067	86,250	0	5,447	65.00
66.00	06600	PHYSICAL THERAPY	56,996	4,229	71,984	5,916	4,546	66.00
67.00	06700	OCCUPATIONAL THERAPY	18,613	4,079	69,432	0	4,385	67.00
68.00	06800	SPEECH PATHOLOGY	20,741	2,082	35,436	0	2,238	68.00
69.00	06900	ELECTROCARDIOLOGY	150,532	19,529	332,425	13,304	20,994	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	708,721	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	118,003	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1,999,981	10,564	179,812	0	11,356	73.00
74.00	07400	RENAL DIALYSIS	115,731	2,140	36,423	0	2,300	74.00
76.00	03950	WAIVER PURCHASED PATIENT SERVICES	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	1,777,446	154,966	2,637,823	20,877	166,590	90.00
91.00	09100	EMERGENCY	862,125	65,634	1,117,223	96,878	70,558	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	15,612,494	1,742,694	17,562,331	718,660	1,073,525	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	DENTISTRY	19,823	4,180	71,155	0	4,494	190.01
190.02	19002	ACHN SATELITE CLINICS	0	0	0	0	0	190.02
190.03	19003	SPECIAL FUNDS	38,231	13,645	232,270	0	14,669	190.03
190.04	19004	SENGSTACKE CLINIC	0	0	0	0	0	190.04
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	21,620	0	0	0	0	194.00
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)	15,692,168	1,760,519	17,865,756	718,660	1,092,688	202.00

ALLOCATION OF CAPITAL RELATED COSTS			Provider CCN: 140124		Period: From 12/01/2011 To 11/30/2012		Worksheet B Part II Date/Time Prepared: 4/30/2013 10:17 am	
Cost Center Description			DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	MEDICAL RECORDS & LIBRARY	
			10.00	11.00	13.00	14.00	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						4.00
5.00	00500	ADMINISTRATIVE & GENERAL						5.00
6.00	00600	MAINTENANCE & REPAIRS						6.00
7.00	00700	OPERATION OF PLANT						7.00
8.00	00800	LAUNDRY & LINEN SERVICE						8.00
9.00	00900	HOUSEKEEPING						9.00
10.00	01000	DIETARY	168,571					10.00
11.00	01100	CAFETERIA	0	1,698,163				11.00
13.00	01300	NURSING ADMINISTRATION	0	17,623	1,110,870			13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	17,552	17,827	2,715,730		14.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	33,557	0	416	1,341,830	16.00
17.00	01700	SOCIAL SERVICE	0	1,953	534	0	0	17.00
18.00	01850	WAI VER OVERHEAD COSTS	0	0	0	0	0	18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	175,620	0	811	0	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	40,575	0	1,173	0	22.00
23.00	02300	ALLIED HEALTH	0	1,137	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	139,683	277,827	247,734	7,336	328,344	30.00
31.00	03100	INTENSIVE CARE UNIT	4,282	39,826	47,151	4,477	31,011	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	979	8,296	8,588	730	5,110	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	997	16,547	19,382	3,008	11,127	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	640	11,350	12,016	0	4,533	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	894	33,297	34,870	5,858	11,456	34.02
34.03	02060	NEURO INTENSIVE CARE UNIT	1,541	13,625	14,935	1,070	8,798	34.03
34.04	02061	NEONATAL INTENSIVE CARE UNIT	0	42,576	42,690	30	38,326	34.04
43.00	04300	NURSERY	0	97	15,972	620	7,418	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	123,699	115,182	8,905	0	50.00
51.00	05100	RECOVERY ROOM	0	12,060	14,611	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	17,574	21,289	1,651	0	52.00
53.00	05300	ANESTHESIOLOGY	0	15,705	13,654	2,951	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	69,478	0	2,775	0	54.00
60.00	06000	LABORATORY	0	103,092	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	7,247	0	70	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	3,861	4,680	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	34,250	35,265	22,571	0	65.00
66.00	06600	PHYSICAL THERAPY	0	8,221	0	132	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	3,068	0	3	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	2,751	0	10	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	26,425	6,703	1,305	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	2,604,807	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	101,602	0	949	0	73.00
74.00	07400	RENAL DIALYSIS	0	12,444	11,365	17,634	8,335	74.00
76.00	03950	WAI VER PURCHASED PATIENT SERVICES	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	4,789	287,388	288,552	15,827	482,171	90.00
91.00	09100	EMERGENCY	14,766	135,314	137,870	10,611	405,201	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS								
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	168,571	1,695,637	1,110,870	2,715,730	1,341,830	118.00
NONREIMBURSABLE COST CENTERS								
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190.01	19001	DENTISTRY	0	379	0	0	0	190.01
190.02	19002	ACHN SATELITTE CLINICS	0	0	0	0	0	190.02
190.03	19003	SPECIAL FUNDS	0	2,147	0	0	0	190.03
190.04	19004	SENGSTACKE CLINIC	0	0	0	0	0	190.04
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194.00
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)	168,571	1,698,163	1,110,870	2,715,730	1,341,830	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140124

Period:
From 12/01/2011
To 11/30/2012

Worksheet B
Part II
Date/Time Prepared:
4/30/2013 10:17 am

Cost Center Description	SOCIAL SERVICE	OTHER GENERAL SERVICE		NONPHYSICIAN ANESTHETISTS	INTERNS & RESIDENTS		
		WAI VER OVERHEAD COSTS			SERVICES-SALARY & FRINGES APPRV	SERVICES-OTHER PRGM COSTS APPRV	
GENERAL SERVICE COST CENTERS							
1.00 00100 CAP REL COSTS-BLDG & FIXT							1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP							2.00
4.00 00400 EMPLOYEE BENEFITS							4.00
5.00 00500 ADMINISTRATIVE & GENERAL							5.00
6.00 00600 MAINTENANCE & REPAIRS							6.00
7.00 00700 OPERATION OF PLANT							7.00
8.00 00800 LAUNDRY & LINEN SERVICE							8.00
9.00 00900 HOUSEKEEPING							9.00
10.00 01000 DIETARY							10.00
11.00 01100 CAFETERIA							11.00
13.00 01300 NURSING ADMINISTRATION							13.00
14.00 01400 CENTRAL SERVICES & SUPPLY							14.00
16.00 01600 MEDICAL RECORDS & LIBRARY							16.00
17.00 01700 SOCIAL SERVICE	165,015						17.00
18.00 01850 WAI VER OVERHEAD COSTS	0	0					18.00
19.00 01900 NONPHYSICIAN ANESTHETISTS	0	0	0				19.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0		970,302			21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0			785,690		22.00
23.00 02300 ALLIED HEALTH	0	0					23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000 ADULTS & PEDIATRICS	49,933	0					30.00
31.00 03100 INTENSIVE CARE UNIT	4,072	0					31.00
33.00 03300 BURN INTENSIVE CARE UNIT	2,027	0					33.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	3,056	0					34.00
34.01 02080 PEDIATRIC INTENSIVE CARE UNIT	2,027	0					34.01
34.02 02180 TRAUMA INTENSIVE CARE UNIT	3,056	0					34.02
34.03 02060 NEURO INTENSIVE CARE UNIT	3,056	0					34.03
34.04 02061 NEONATAL INTENSIVE CARE UNIT	3,056	0					34.04
43.00 04300 NURSERY	0	0					43.00
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
60.00 06000 LABORATORY	0	0					60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0					62.00
64.00 06400 INTRAVENOUS THERAPY	0	0					64.00
65.00 06500 RESPIRATORY THERAPY	0	0					65.00
66.00 06600 PHYSICAL THERAPY	0	0					66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0					67.00
68.00 06800 SPEECH PATHOLOGY	0	0					68.00
69.00 06900 ELECTROCARDIOLOGY	0	0					69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO 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	6,112	0					74.00
76.00 03950 WAI VER PURCHASED PATIENT SERVICES	0	0					76.00
OUTPATIENT SERVICE COST CENTERS							
90.00 09000 CLINIC	58,062	0					90.00
91.00 09100 EMERGENCY	30,558	0					91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART							92.00
OTHER REIMBURSABLE COST CENTERS							
98.00 05950 OTHER REIMBURSABLE COST CENTERS	0	0					98.00
SPECIAL PURPOSE COST CENTERS							
113.00 11300 INTEREST EXPENSE							113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	165,015	0	0	0	0	0	118.00
NONREIMBURSABLE COST CENTERS							
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0					190.00
190.01 19001 DENTISTRY	0	0					190.01
190.02 19002 ACHN SATELLITE CLINICS	0	0					190.02
190.03 19003 SPECIAL FUNDS	0	0					190.03
190.04 19004 SENGSTACKE CLINIC	0	0					190.04
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	0					194.00
200.00 Cross Foot Adjustments				0	970,302	785,690	200.00
201.00 Negative Cost Centers	0	0		0	0	0	201.00
202.00 TOTAL (sum lines 118-201)	165,015	0	0	0	970,302	785,690	202.00

ALLOCATION OF CAPITAL RELATED COSTS				Provider CCN: 140124	Period: From 12/01/2011 To 11/30/2012	Worksheet B Part II Date/Time Prepared: 4/30/2013 10:17 am
Cost Center Description			ALLIED HEALTH	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total
			23.00	24.00	25.00	26.00
GENERAL SERVICE COST CENTERS						
1.00	00100	CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200	CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400	EMPLOYEE BENEFITS				4.00
5.00	00500	ADMINISTRATIVE & GENERAL				5.00
6.00	00600	MAINTENANCE & REPAIRS				6.00
7.00	00700	OPERATION OF PLANT				7.00
8.00	00800	LAUNDRY & LINEN SERVICE				8.00
9.00	00900	HOUSEKEEPING				9.00
10.00	01000	DIETARY				10.00
11.00	01100	CAFETERIA				11.00
13.00	01300	NURSING ADMINISTRATION				13.00
14.00	01400	CENTRAL SERVICES & SUPPLY				14.00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
17.00	01700	SOCIAL SERVICE				17.00
18.00	01850	WAIVER OVERHEAD COSTS				18.00
19.00	01900	NONPHYSICIAN ANESTHETISTS				19.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRV				21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRV				22.00
23.00	02300	ALLIED HEALTH	12,598			23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000	ADULTS & PEDIATRICS		16,769,702	0	30.00
31.00	03100	INTENSIVE CARE UNIT		1,535,826	0	31.00
33.00	03300	BURN INTENSIVE CARE UNIT		344,780	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		548,365	0	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT		366,292	0	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT		1,294,236	0	34.02
34.03	02060	NEURO INTENSIVE CARE UNIT		320,764	0	34.03
34.04	02061	NEONATAL INTENSIVE CARE UNIT		950,951	0	34.04
43.00	04300	NURSERY		447,299	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000	OPERATING ROOM		4,796,667	0	50.00
51.00	05100	RECOVERY ROOM		661,719	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM		723,087	0	52.00
53.00	05300	ANESTHESIOLOGY		430,941	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC		4,556,054	0	54.00
60.00	06000	LABORATORY		3,890,738	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL		264,609	0	62.00
64.00	06400	INTRAVENOUS THERAPY		423,028	0	64.00
65.00	06500	RESPIRATORY THERAPY		1,130,988	0	65.00
66.00	06600	PHYSICAL THERAPY		257,475	0	66.00
67.00	06700	OCCUPATIONAL THERAPY		191,535	0	67.00
68.00	06800	SPEECH PATHOLOGY		125,664	0	68.00
69.00	06900	ELECTROCARDIOLOGY		1,342,271	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT		3,313,528	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		118,003	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS		3,169,950	0	73.00
74.00	07400	RENAL DIALYSIS		281,065	0	74.00
76.00	03950	WAIVER PURCHASED PATIENT SERVICES		0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000	CLINIC		10,747,388	0	90.00
91.00	09100	EMERGENCY		4,567,133	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART			0	92.00
OTHER REIMBURSABLE COST CENTERS						
98.00	05950	OTHER REIMBURSABLE COST CENTERS		0	0	98.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300	INTEREST EXPENSE				113.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	63,570,058	0	118.00
NONREIMBURSABLE COST CENTERS						
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN		0	0	190.00
190.01	19001	DENTISTRY		194,864	0	190.01
190.02	19002	ACHN SATELLITE CLINICS		0	0	190.02
190.03	19003	SPECIAL FUNDS		607,591	0	190.03
190.04	19004	SENGSTACKE CLINIC		0	0	190.04
194.00	07950	OTHER NONREIMBURSABLE COST CENTERS		21,620	0	194.00
200.00		Cross Foot Adjustments	12,598	1,768,590	0	200.00
201.00		Negative Cost Centers	0	0	0	201.00
202.00		TOTAL (sum lines 118-201)	12,598	66,162,723	0	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140124

Period:
From 12/01/2011
To 11/30/2012

Worksheet B-1
Date/Time Prepared:
4/30/2013 10:17 am

Cost Center Description	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
	1.00	2.00				
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT	2,361,718				1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP		7,342,640			2.00
4.00 00400	EMPLOYEE BENEFITS	19,108	13,182	365,960,237		4.00
5.00 00500	ADMINISTRATIVE & GENERAL	357,312	459,575	19,193,504	-154,498,395	5.00
6.00 00600	MAINTENANCE & REPAIRS	71,543	22,137	5,869,926	0	6.00
7.00 00700	OPERATION OF PLANT	772,830	19,167	9,442,324	0	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	17,530	177	200,012	0	8.00
9.00 00900	HOUSEKEEPING	18,483	7,145	7,757,611	0	9.00
10.00 01000	DIETARY	1,007	496	2,787,720	0	10.00
11.00 01100	CAFETERIA	42,074	26,632	1,053,641	0	11.00
13.00 01300	NURSING ADMINISTRATION	11,290	101,176	3,173,119	0	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	63,986	110,803	1,814,333	0	14.00
16.00 01600	MEDICAL RECORDS & LIBRARY	29,816	3,020	3,566,607	0	16.00
17.00 01700	SOCIAL SERVICE	3,618	174	585,559	0	17.00
18.00 01850	WAI VER OVERHEAD COSTS	0	0	0	0	18.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0	0	0	19.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	1,039	1,847	18,922,382	0	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	20,079,713	0	22.00
23.00 02300	ALLIED HEALTH	125	0	47,821	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	269,454	3,109,545	61,056,469	0	30.00
31.00 03100	INTENSIVE CARE UNIT	28,051	4,600	8,345,249	0	31.00
33.00 03300	BURN INTENSIVE CARE UNIT	5,988	1,500	2,193,049	0	33.00
34.00 03400	SURGICAL INTENSIVE CARE UNIT	9,435	0	3,471,753	0	34.00
34.01 02080	PEDIATRIC INTENSIVE CARE UNIT	6,647	1,568	2,553,954	0	34.01
34.02 02180	TRAUMA INTENSIVE CARE UNIT	22,684	48,921	7,172,105	0	34.02
34.03 02060	NEURO INTENSIVE CARE UNIT	4,740	0	3,180,690	0	34.03
34.04 02061	NEONATAL INTENSIVE CARE UNIT	12,087	26,026	10,421,668	0	34.04
43.00 04300	NURSERY	8,647	0	2,321,886	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	69,211	997,807	28,169,468	0	50.00
51.00 05100	RECOVERY ROOM	13,355	886	2,417,320	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	13,232	0	3,517,578	0	52.00
53.00 05300	ANESTHESIOLOGY	4,615	138,555	5,121,396	0	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	83,203	557,970	14,960,570	0	54.00
60.00 06000	LABORATORY	76,927	172,059	16,079,380	0	60.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELL	2,758	403	1,033,505	0	62.00
64.00 06400	INTRAVENOUS THERAPY	9,905	0	813,669	0	64.00
65.00 06500	RESPIRATORY THERAPY	5,508	243,511	6,480,982	0	65.00
66.00 06600	PHYSICAL THERAPY	4,597	8,187	1,481,233	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	4,434	0	440,593	0	67.00
68.00 06800	SPEECH PATHOLOGY	2,263	14,496	417,531	0	68.00
69.00 06900	ELECTROCARDIOLOGY	21,229	311,350	5,199,002	0	69.00
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	11,483	600,700	0	0	73.00
74.00 07400	RENAL DIALYSIS	2,326	15,555	2,926,283	0	74.00
76.00 03950	WAI VER PURCHASED PATIENT SERVICES	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	168,454	214,542	55,194,335	0	90.00
91.00 09100	EMERGENCY	71,347	107,784	25,628,493	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS						
98.00 05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	2,342,341	7,341,496	365,092,433	-154,498,395	561,588,501
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	190.00
190.01 19001	DENTISTRY	4,544	1,144	51,594	0	190.01
190.02 19002	ACHN SATELITTE CLINICS	0	0	0	0	190.02
190.03 19003	SPECIAL FUNDS	14,833	0	816,210	0	190.03
190.04 19004	SENGSTACKE CLINIC	0	0	0	0	190.04
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	194.00
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)	48,626,398	7,691,719	113,692,374		154,498,395
203.00	Unit cost multiplier (Wkst. B, Part I)	20.589418	1.047541	0.310669		0.273713

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140124

Period:
From 12/01/2011
To 11/30/2012

Worksheet B-1
Date/Time Prepared:
4/30/2013 10:17 am

Cost Center Description		CAPITAL RELATED COSTS		EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)				
		1.00	2.00				
204.00	Cost to be allocated (per Wkst. B, Part II)			549,678	5A	15,692,168	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)			0.001502		0.027801	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140124

Period:
From 12/01/2011
To 11/30/2012

Worksheet B-1

Date/Time Prepared:
4/30/2013 10:17 am

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
6.00	00600	1,913,755					6.00
7.00	00700	772,830	1,140,925				7.00
8.00	00800	17,530	17,530	2,388,223			8.00
9.00	00900	18,483	18,483	75,459	1,104,912		9.00
10.00	01000	1,007	1,007	18,170	1,007	491,048	10.00
11.00	01100	42,074	42,074	0	42,074	0	11.00
13.00	01300	11,290	11,290	0	11,290	0	13.00
14.00	01400	63,986	63,986	20,040	63,986	0	14.00
16.00	01600	29,816	29,816	0	29,816	0	16.00
17.00	01700	3,618	3,618	0	3,618	0	17.00
18.00	01850	0	0	0	0	0	18.00
19.00	01900	0	0	0	0	0	19.00
21.00	02100	1,039	1,039	0	1,039	0	21.00
22.00	02200	0	0	0	0	0	22.00
23.00	02300	125	125	0	125	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	269,454	269,454	787,931	269,454	406,899	30.00
31.00	03100	28,051	28,051	0	28,051	12,474	31.00
33.00	03300	5,988	5,988	65,965	5,988	2,853	33.00
34.00	03400	9,435	9,435	0	9,435	2,904	34.00
34.01	02080	6,647	6,647	0	6,647	1,863	34.01
34.02	02180	22,684	22,684	114,713	22,684	2,603	34.02
34.03	02060	4,740	4,740	10,021	4,740	4,490	34.03
34.04	02061	12,087	12,087	91,092	12,087	0	34.04
43.00	04300	8,647	8,647	0	8,647	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	69,211	69,211	246,460	69,211	0	50.00
51.00	05100	13,355	13,355	83,447	13,355	0	51.00
52.00	05200	13,232	13,232	130,679	13,232	0	52.00
53.00	05300	4,615	4,615	9,477	4,615	0	53.00
54.00	05400	83,203	83,203	279,579	83,203	0	54.00
60.00	06000	76,927	76,927	0	76,927	0	60.00
62.00	06200	2,758	2,758	0	2,758	0	62.00
64.00	06400	9,905	9,905	0	9,905	0	64.00
65.00	06500	5,508	5,508	0	5,508	0	65.00
66.00	06600	4,597	4,597	19,661	4,597	0	66.00
67.00	06700	4,434	4,434	0	4,434	0	67.00
68.00	06800	2,263	2,263	0	2,263	0	68.00
69.00	06900	21,229	21,229	44,210	21,229	0	69.00
71.00	07100	0	0	0	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	11,483	11,483	0	11,483	0	73.00
74.00	07400	2,326	2,326	0	2,326	0	74.00
76.00	03950	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	168,454	168,454	69,377	168,454	13,950	90.00
91.00	09100	71,347	71,347	321,942	71,347	43,012	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
98.00	05950	0	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		1,894,378	1,121,548	2,388,223	1,085,535	491,048	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
190.01	19001	4,544	4,544	0	4,544	0	190.01
190.02	19002	0	0	0	0	0	190.02
190.03	19003	14,833	14,833	0	14,833	0	190.03
190.04	19004	0	0	0	0	0	190.04
194.00	07950	0	0	0	0	0	194.00
200.00							200.00
201.00							201.00
202.00		11,705,101	59,879,903	4,079,258	17,882,443	5,602,859	202.00
203.00		6.116301	52.483645	1.708072	16.184495	11.410003	203.00
204.00		1,760,519	17,865,756	718,660	1,092,688	168,571	204.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140124

Period:
From 12/01/2011
To 11/30/2012

Worksheet B-1

Date/Time Prepared:
4/30/2013 10:17 am

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (SQUARE FEET)	DIETARY (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	
205.00	Unit cost multiplier (Wkst. B, Part II)	0.919929	15.659010	0.300918	0.988937	0.343288	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140124

Period:
From 12/01/2011
To 11/30/2012

Worksheet B-1

Date/Time Prepared:
4/30/2013 10:17 am

Cost Center Description		CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NRSNG HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	
		11.00	13.00	14.00	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
6.00	00600						6.00
7.00	00700						7.00
8.00	00800						8.00
9.00	00900						9.00
10.00	01000						10.00
11.00	01100	385,253					11.00
13.00	01300	3,998	4,310,425				13.00
14.00	01400	3,982	69,173	30,991,094			14.00
16.00	01600	7,613	0	4,750	130,242		16.00
17.00	01700	443	2,072	0	0	56,160	17.00
18.00	01850	0	0	0	0	0	18.00
19.00	01900	0	0	0	0	0	19.00
21.00	02100	39,842	0	9,256	0	0	21.00
22.00	02200	9,205	0	13,384	0	0	22.00
23.00	02300	258	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	63,029	961,265	83,713	31,870	16,994	30.00
31.00	03100	9,035	182,956	51,086	3,010	1,386	31.00
33.00	03300	1,882	33,322	8,332	496	690	33.00
34.00	03400	3,754	75,208	34,325	1,080	1,040	34.00
34.01	02080	2,575	46,626	0	440	690	34.01
34.02	02180	7,554	135,304	66,845	1,112	1,040	34.02
34.03	02060	3,091	57,950	12,210	854	1,040	34.03
34.04	02061	9,659	165,645	339	3,720	1,040	34.04
43.00	04300	22	61,976	7,073	720	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	28,063	446,934	101,619	0	0	50.00
51.00	05100	2,736	56,693	0	0	0	51.00
52.00	05200	3,987	82,606	18,845	0	0	52.00
53.00	05300	3,563	52,981	33,681	0	0	53.00
54.00	05400	15,762	0	31,664	0	0	54.00
60.00	06000	23,388	0	0	0	0	60.00
62.00	06200	1,644	0	802	0	0	62.00
64.00	06400	876	18,159	0	0	0	64.00
65.00	06500	7,770	136,837	257,572	0	0	65.00
66.00	06600	1,865	0	1,511	0	0	66.00
67.00	06700	696	0	30	0	0	67.00
68.00	06800	624	0	116	0	0	68.00
69.00	06900	5,995	26,009	14,891	0	0	69.00
71.00	07100	0	0	29,725,275	0	0	71.00
72.00	07200	0	0	0	0	0	72.00
73.00	07300	23,050	0	10,834	0	0	73.00
74.00	07400	2,823	44,097	201,234	809	2,080	74.00
76.00	03950	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	65,198	1,119,644	180,616	46,801	19,760	90.00
91.00	09100	30,698	534,968	121,091	39,330	10,400	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
98.00	05950	0	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300						113.00
118.00		384,680	4,310,425	30,991,094	130,242	56,160	118.00
NONREIMBURSABLE COST CENTERS							
190.00	19000	0	0	0	0	0	190.00
190.01	19001	86	0	0	0	0	190.01
190.02	19002	0	0	0	0	0	190.02
190.03	19003	487	0	0	0	0	190.03
190.04	19004	0	0	0	0	0	190.04
194.00	07950	0	0	0	0	0	194.00
200.00							200.00
201.00							201.00
202.00		6,044,371	7,382,463	10,222,906	9,756,287	1,353,726	202.00
203.00		15.689355	1.712700	0.329866	74.908916	24.104808	203.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140124

Period:
From 12/01/2011
To 11/30/2012

Worksheet B-1

Date/Time Prepared:
4/30/2013 10:17 am

Cost Center Description		CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NRSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	
		11.00	13.00	14.00	16.00	17.00	
204.00	Cost to be allocated (per Wkst. B, Part II)	1,698,163	1,110,870	2,715,730	1,341,830	165,015	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	4.407916	0.257717	0.087629	10.302591	2.938301	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140124

Period:
From 12/01/2011
To 11/30/2012

Worksheet B-1

Date/Time Prepared:
4/30/2013 10:17 am

Cost Center Description	OTHER GENERAL SERVICE	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	INTERNS & RESIDENTS		ALLIED HEALTH (ASSIGNED TIME)	
	WAIVER OVERHEAD COSTS (TIME SPENT)		SERVICES-SALARY & FRINGES APPRV (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)		
	18.00		19.00	21.00		
GENERAL SERVICE COST CENTERS						
1.00 00100	CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS					4.00
5.00 00500	ADMINISTRATIVE & GENERAL					5.00
6.00 00600	MAINTENANCE & REPAIRS					6.00
7.00 00700	OPERATION OF PLANT					7.00
8.00 00800	LAUNDRY & LINEN SERVICE					8.00
9.00 00900	HOUSEKEEPING					9.00
10.00 01000	DIETARY					10.00
11.00 01100	CAFETERIA					11.00
13.00 01300	NURSING ADMINISTRATION					13.00
14.00 01400	CENTRAL SERVICES & SUPPLY					14.00
16.00 01600	MEDICAL RECORDS & LIBRARY					16.00
17.00 01700	SOCIAL SERVICE					17.00
18.00 01850	WAIVER OVERHEAD COSTS	0				18.00
19.00 01900	NONPHYSICIAN ANESTHETISTS	0	0			19.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRV	0		45,308		21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRV	0			45,308	22.00
23.00 02300	ALLIED HEALTH	0				10,000 23.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0		13,568	13,568	0 30.00
31.00 03100	INTENSIVE CARE UNIT	0		1,701	1,701	0 31.00
33.00 03300	BURN INTENSIVE CARE UNIT	0		364	364	0 33.00
34.00 03400	SURGICAL INTENSIVE CARE UNIT	0		470	470	0 34.00
34.01 02080	PEDIATRIC INTENSIVE CARE UNIT	0		200	200	0 34.01
34.02 02180	TRAUMA INTENSIVE CARE UNIT	0		0	0	0 34.02
34.03 02060	NEURO INTENSIVE CARE UNIT	0		244	244	0 34.03
34.04 02061	NEONATAL INTENSIVE CARE UNIT	0		916	916	0 34.04
43.00 04300	NURSERY	0		296	296	0 43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	0	6,289	6,289	0 50.00
51.00 05100	RECOVERY ROOM	0	0	0	0	0 51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	385	385	0 52.00
53.00 05300	ANESTHESIOLOGY	0	0	2,589	2,589	0 53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	0	1,703	1,703	0 54.00
60.00 06000	LABORATORY	0	0	189	189	0 60.00
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0 62.00
64.00 06400	INTRAVENOUS THERAPY	0	0	111	111	0 64.00
65.00 06500	RESPIRATORY THERAPY	0	0	960	960	0 65.00
66.00 06600	PHYSICAL THERAPY	0	0	0	0	0 66.00
67.00 06700	OCCUPATIONAL THERAPY	0	0	30	30	0 67.00
68.00 06800	SPEECH PATHOLOGY	0	0	0	0	0 68.00
69.00 06900	ELECTROCARDIOLOGY	0	0	1,410	1,410	0 69.00
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	10,000 73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0	0 74.00
76.00 03950	WAIVER PURCHASED PATIENT SERVICES	0	0	0	0	0 76.00
OUTPATIENT SERVICE COST CENTERS						
90.00 09000	CLINIC	0	0	6,503	6,503	0 90.00
91.00 09100	EMERGENCY	0	0	7,380	7,380	0 91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS						
98.00 05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0 98.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300	INTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	0	45,308	45,308	10,000 118.00
NONREIMBURSABLE COST CENTERS						
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0 190.00
190.01 19001	DENTISTRY	0	0	0	0	0 190.01
190.02 19002	ACHN SATELITTE CLINICS	0	0	0	0	0 190.02
190.03 19003	SPECIAL FUNDS	0	0	0	0	0 190.03
190.04 19004	SENGSTACKE CLINIC	0	0	0	0	0 190.04
194.00 07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0 194.00
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	0	0	33,870,168	32,851,016	316,665 202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140124

Period:
From 12/01/2011
To 11/30/2012

Worksheet B-1

Date/Time Prepared:
4/30/2013 10:17 am

Cost Center Description		OTHER GENERAL SERVICE	NONPHYSICIAN ANESTHETISTS (ASSIGNED TIME)	INTERNS & RESIDENTS		ALLIED HEALTH (ASSIGNED TIME)	
		WAIVER OVERHEAD COSTS (TIME SPENT)		SERVICES-SALARY & FRINGES APPRV (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME)		
		18.00	19.00	21.00	22.00	23.00	
203.00	Unit cost multiplier (Wkst. B, Part I)	0.000000	0.000000	747.553809	725.059945	31.666500	203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	0	0	970,302	785,690	12,598	204.00
205.00	Unit cost multiplier (Wkst. B, Part II)	0.000000	0.000000	21.415688	17.341088	1.259800	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140124

Period:
From 12/01/2011
To 11/30/2012

Worksheet C
Part I
Date/Time Prepared:
4/30/2013 10:17 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		115,185,745	4,190,908	119,376,653	30.00
31.00	03100 INTENSIVE CARE UNIT		17,508,237	205,296	17,713,533	31.00
33.00	03300 BURN INTENSIVE CARE UNIT		3,753,080	164,479	3,917,559	33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT		6,954,735	16,777	6,971,512	34.00
34.01	02080 PEDIATRIC INTENSIVE CARE UNIT		4,198,378	103,530	4,301,908	34.01
34.02	02180 TRAUMA INTENSIVE CARE UNIT		13,522,397	126,528	13,648,925	34.02
34.03	02060 NEURO INTENSIVE CARE UNIT		4,744,906	68,406	4,813,312	34.03
34.04	02061 NEONATAL INTENSIVE CARE UNIT		15,210,594	256,464	15,467,058	34.04
43.00	04300 NURSERY		4,921,758	0	4,921,758	43.00
ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM		41,026,238	1,509,851	42,536,089	50.00
51.00	05100 RECOVERY ROOM		5,669,831	0	5,669,831	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		7,519,574	0	7,519,574	52.00
53.00	05300 ANESTHESIOLOGY		3,581,844	1,304,317	4,886,161	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC		35,266,961	395,420	35,662,381	54.00
60.00	06000 LABORATORY		35,805,025	338,180	36,143,205	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL		7,108,301	0	7,108,301	62.00
64.00	06400 INTRAVENOUS THERAPY		2,403,696	0	2,403,696	64.00
65.00	06500 RESPIRATORY THERAPY	0	10,258,054	223,490	10,481,544	65.00
66.00	06600 PHYSICAL THERAPY	0	3,018,396	0	3,018,396	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	1,195,294	0	1,195,294	67.00
68.00	06800 SPEECH PATHOLOGY	0	1,129,308	0	1,129,308	68.00
69.00	06900 ELECTROCARDIOLOGY		8,703,320	308,977	9,012,297	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		42,275,653	0	42,275,653	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		5,406,336	0	5,406,336	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		93,180,854	0	93,180,854	73.00
74.00	07400 RENAL DIALYSIS		5,773,147	0	5,773,147	74.00
76.00	03950 WAIVER PURCHASED PATIENT SERVICES	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC		101,291,974	1,442,940	102,734,914	90.00
91.00	09100 EMERGENCY		50,509,552	1,897,046	52,406,598	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		3,553,991	0	3,553,991	92.00
OTHER REIMBURSABLE COST CENTERS						
98.00	05950 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	98.00
SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE					113.00
200.00	Subtotal (see instructions)	0	650,677,179	12,552,609	663,229,788	200.00
201.00	Less Observation Beds		3,553,991		3,553,991	201.00
202.00	Total (see instructions)	0	647,123,188	12,552,609	659,675,797	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140124

Period:
From 12/01/2011
To 11/30/2012

Worksheet C
Part I
Date/Time Prepared:
4/30/2013 10:17 am

		Title XVIIII			Hospital	PPS	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	141,136,272		141,136,272		30.00
31.00	03100	INTENSIVE CARE UNIT	16,933,950		16,933,950		31.00
33.00	03300	BURN INTENSIVE CARE UNIT	2,790,018		2,790,018		33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	6,074,442		6,074,442		34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	2,474,208		2,474,208		34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	6,253,038		6,253,038		34.02
34.03	02060	NEURO INTENSIVE CARE UNIT	4,804,668		4,804,668		34.03
34.04	02061	NEONATAL INTENSIVE CARE UNIT	20,928,402		20,928,402		34.04
43.00	04300	NURSERY	713,856		713,856		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	24,953,077	17,583,012	42,536,089	0.964504	50.00
51.00	05100	RECOVERY ROOM	3,326,110	2,343,721	5,669,831	1.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,519,574	0	7,519,574	1.000000	52.00
53.00	05300	ANESTHESIOLOGY	2,866,383	2,019,778	4,886,161	0.733059	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,104,800	22,557,581	35,662,381	0.988912	54.00
60.00	06000	LABORATORY	13,736,840	22,406,365	36,143,205	0.990643	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	6,139,258	969,043	7,108,301	1.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	1,527,341	876,355	2,403,696	1.000000	64.00
65.00	06500	RESPIRATORY THERAPY	10,240,785	240,759	10,481,544	0.978678	65.00
66.00	06600	PHYSICAL THERAPY	1,317,853	1,700,543	3,018,396	1.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	362,999	832,295	1,195,294	1.000000	67.00
68.00	06800	SPEECH PATHOLOGY	149,595	979,713	1,129,308	1.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,608,935	7,403,362	9,012,297	0.965716	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	27,112,818	15,162,835	42,275,653	1.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,513,939	1,892,397	5,406,336	1.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	36,651,075	56,529,779	93,180,854	1.000000	73.00
74.00	07400	RENAL DIALYSIS	2,898,320	2,874,827	5,773,147	1.000000	74.00
76.00	03950	WAIVER PURCHASED PATIENT SERVICES	0	0	0	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	102,734,914	102,734,914	0.985955	90.00
91.00	09100	EMERGENCY	3,157,446	49,249,152	52,406,598	0.963801	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,753,285	2,449,829	4,203,114	0.845561	92.00
OTHER REIMBURSABLE COST CENTERS							
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0.000000	98.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	364,049,287	310,806,260	674,855,547		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	364,049,287	310,806,260	674,855,547		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140124	Period: From 12/01/2011 To 11/30/2012	Worksheet C Part I Date/Time Prepared: 4/30/2013 10:17 am
		Title XVIII	Hospital	PPS

Cost Center Description		PPS Inpatient Ratio		
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
33.00	03300	BURN INTENSIVE CARE UNIT		33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT		34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT		34.02
34.03	02060	NEURO INTENSIVE CARE UNIT		34.03
34.04	02061	NEONATAL INTENSIVE CARE UNIT		34.04
43.00	04300	NURSERY		43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	1.000000	50.00
51.00	05100	RECOVERY ROOM	1.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.000000	52.00
53.00	05300	ANESTHESIOLOGY	1.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1.000000	54.00
60.00	06000	LABORATORY	1.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	1.000000	64.00
65.00	06500	RESPIRATORY THERAPY	1.000000	65.00
66.00	06600	PHYSICAL THERAPY	1.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	1.000000	67.00
68.00	06800	SPEECH PATHOLOGY	1.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1.000000	73.00
74.00	07400	RENAL DIALYSIS	1.000000	74.00
76.00	03950	WAIVER PURCHASED PATIENT SERVICES	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	1.000000	90.00
91.00	09100	EMERGENCY	1.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.845561	92.00
OTHER REIMBURSABLE COST CENTERS				
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0.000000	98.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
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: 140124

Period:
From 12/01/2011
To 11/30/2012

Worksheet C
Part I
Date/Time Prepared:
4/30/2013 10:17 am

		Title XIX		Hospital		Cost		
Cost Center Description		Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs		Total Costs		
				Total Costs	RCE Disallowance			
		1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	115,185,745		115,185,745	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	17,508,237		17,508,237	0	0	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	3,753,080		3,753,080	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	6,954,735		6,954,735	0	0	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	4,198,378		4,198,378	0	0	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	13,522,397		13,522,397	0	0	34.02
34.03	02060	NEURO INTENSIVE CARE UNIT	4,744,906		4,744,906	0	0	34.03
34.04	02061	NEONATAL INTENSIVE CARE UNIT	15,210,594		15,210,594	0	0	34.04
43.00	04300	NURSERY	4,921,758		4,921,758	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	41,026,238		41,026,238	0	0	50.00
51.00	05100	RECOVERY ROOM	5,669,831		5,669,831	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,519,574		7,519,574	0	0	52.00
53.00	05300	ANESTHESIOLOGY	3,581,844		3,581,844	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	35,266,961		35,266,961	0	0	54.00
60.00	06000	LABORATORY	35,805,025		35,805,025	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	7,108,301		7,108,301	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	2,403,696		2,403,696	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	10,258,054	0	10,258,054	0	0	65.00
66.00	06600	PHYSICAL THERAPY	3,018,396	0	3,018,396	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1,195,294	0	1,195,294	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	1,129,308	0	1,129,308	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	8,703,320		8,703,320	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	42,275,653		42,275,653	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	5,406,336		5,406,336	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	93,180,854		93,180,854	0	0	73.00
74.00	07400	RENAL DIALYSIS	5,773,147		5,773,147	0	0	74.00
76.00	03950	WAIVER PURCHASED PATIENT SERVICES	0		0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	101,291,974		101,291,974	0	0	90.00
91.00	09100	EMERGENCY	50,509,552		50,509,552	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	3,553,991		3,553,991	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0		0	0	0	98.00
SPECIAL PURPOSE COST CENTERS								
113.00	11300	INTEREST EXPENSE						113.00
200.00		Subtotal (see instructions)	650,677,179	0	650,677,179	0	0	200.00
201.00		Less Observation Beds	3,553,991		3,553,991			201.00
202.00		Total (see instructions)	647,123,188	0	647,123,188	0	0	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140124

Period:
From 12/01/2011
To 11/30/2012

Worksheet C
Part I
Date/Time Prepared:
4/30/2013 10:17 am

		Title XIX			Hospital	Cost	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	141,136,272		141,136,272		30.00
31.00	03100	INTENSIVE CARE UNIT	16,933,950		16,933,950		31.00
33.00	03300	BURN INTENSIVE CARE UNIT	2,790,018		2,790,018		33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	6,074,442		6,074,442		34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	2,474,208		2,474,208		34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	6,253,038		6,253,038		34.02
34.03	02060	NEURO INTENSIVE CARE UNIT	4,804,668		4,804,668		34.03
34.04	02061	NEONATAL INTENSIVE CARE UNIT	20,928,402		20,928,402		34.04
43.00	04300	NURSERY	713,856		713,856		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	24,953,077	17,583,012	42,536,089	0.964504	50.00
51.00	05100	RECOVERY ROOM	3,326,110	2,343,721	5,669,831	1.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	7,519,574	0	7,519,574	1.000000	52.00
53.00	05300	ANESTHESIOLOGY	2,866,383	2,019,778	4,886,161	0.733059	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	13,104,800	22,557,581	35,662,381	0.988912	54.00
60.00	06000	LABORATORY	13,736,840	22,406,365	36,143,205	0.990643	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	6,139,258	969,043	7,108,301	1.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	1,527,341	876,355	2,403,696	1.000000	64.00
65.00	06500	RESPIRATORY THERAPY	10,240,785	240,759	10,481,544	0.978678	65.00
66.00	06600	PHYSICAL THERAPY	1,317,853	1,700,543	3,018,396	1.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	362,999	832,295	1,195,294	1.000000	67.00
68.00	06800	SPEECH PATHOLOGY	149,595	979,713	1,129,308	1.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	1,608,935	7,403,362	9,012,297	0.965716	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	27,112,818	15,162,835	42,275,653	1.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	3,513,939	1,892,397	5,406,336	1.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	36,651,075	56,529,779	93,180,854	1.000000	73.00
74.00	07400	RENAL DIALYSIS	2,898,320	2,874,827	5,773,147	1.000000	74.00
76.00	03950	WAIVER PURCHASED PATIENT SERVICES	0	0	0	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000	CLINIC	0	102,734,914	102,734,914	0.985955	90.00
91.00	09100	EMERGENCY	3,157,446	49,249,152	52,406,598	0.963801	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	1,753,285	2,449,829	4,203,114	0.845561	92.00
OTHER REIMBURSABLE COST CENTERS							
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0.000000	98.00
SPECIAL PURPOSE COST CENTERS							
113.00	11300	INTEREST EXPENSE					113.00
200.00		Subtotal (see instructions)	364,049,287	310,806,260	674,855,547		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	364,049,287	310,806,260	674,855,547		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140124	Period: From 12/01/2011 To 11/30/2012	Worksheet C Part I Date/Time Prepared: 4/30/2013 10:17 am
Cost Center Description		PPS Inpatient Ratio	Title XIX	Hospital Cost
		11.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS		30.00
31.00	03100	INTENSIVE CARE UNIT		31.00
33.00	03300	BURN INTENSIVE CARE UNIT		33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT		34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT		34.02
34.03	02060	NEURO INTENSIVE CARE UNIT		34.03
34.04	02061	NEONATAL INTENSIVE CARE UNIT		34.04
43.00	04300	NURSERY		43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0.000000	50.00
51.00	05100	RECOVERY ROOM	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	0.000000	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.000000	54.00
60.00	06000	LABORATORY	0.000000	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000	62.00
64.00	06400	INTRAVENOUS THERAPY	0.000000	64.00
65.00	06500	RESPIRATORY THERAPY	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	0.000000	66.00
67.00	06700	OCCUPATIONAL THERAPY	0.000000	67.00
68.00	06800	SPEECH PATHOLOGY	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	0.000000	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0.000000	73.00
74.00	07400	RENAL DIALYSIS	0.000000	74.00
76.00	03950	WAIVER PURCHASED PATIENT SERVICES	0.000000	76.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000	CLINIC	0.000000	90.00
91.00	09100	EMERGENCY	0.000000	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS				
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0.000000	98.00
SPECIAL PURPOSE COST CENTERS				
113.00	11300	INTEREST EXPENSE		113.00
200.00		Subtotal (see instructions)		200.00
201.00		Less Observation Beds		201.00
202.00		Total (see instructions)		202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 140124	Period: From 12/01/2011 To 11/30/2012	Worksheet D Part I Date/Time Prepared: 4/30/2013 10:17 am
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Cost Center Description		Title XVIII			Hospital	PPS	
		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	16,769,702	0	16,769,702	84,041	199.54	30.00
31.00	03100 INTENSIVE CARE UNIT	1,535,826		1,535,826	7,775	197.53	31.00
33.00	03300 BURN INTENSIVE CARE UNIT	344,780		344,780	1,281	269.15	33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	548,365		548,365	2,789	196.62	34.00
34.01	02080 PEDIATRIC INTENSIVE CARE UNIT	366,292		366,292	1,136	322.44	34.01
34.02	02180 TRAUMA INTENSIVE CARE UNIT	1,294,236		1,294,236	2,871	450.80	34.02
34.03	02060 NEURO INTENSIVE CARE UNIT	320,764		320,764	2,206	145.41	34.03
34.04	02061 NEONATAL INTENSIVE CARE UNIT	950,951		950,951	9,609	98.96	34.04
43.00	04300 NURSERY	447,299		447,299	1,859	240.61	43.00
200.00	Total (lines 30-199)	22,578,215		22,578,215	113,567		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 140124	Period: From 12/01/2011 To 11/30/2012	Worksheet D Part I Date/Time Prepared: 4/30/2013 10:17 am
		Title XVIII	Hospital	PPS

Cost Center Description		Inpatient Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	
		6.00	7.00	
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS	9,821	1,959,682	30.00
31.00	03100 INTENSIVE CARE UNIT	1,024	202,271	31.00
33.00	03300 BURN INTENSIVE CARE UNIT	169	45,486	33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	367	72,160	34.00
34.01	02080 PEDIATRIC INTENSIVE CARE UNIT	0	0	34.01
34.02	02180 TRAUMA INTENSIVE CARE UNIT	378	170,402	34.02
34.03	02060 NEURO INTENSIVE CARE UNIT	291	42,314	34.03
34.04	02061 NEONATAL INTENSIVE CARE UNIT	0	0	34.04
43.00	04300 NURSERY	0	0	43.00
200.00	Total (lines 30-199)	12,050	2,492,315	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 140124	Period: From 12/01/2011 To 11/30/2012	Worksheet D Part II Date/Time Prepared: 4/30/2013 10:17 am
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Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 1 ÷ col. 2)	Inpatient Program Charges	Capital Costs (column 3 x column 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	4,796,667	42,536,089	0.112767	2,737,979	308,754	50.00
51.00	05100 RECOVERY ROOM	661,719	5,669,831	0.116709	364,958	42,594	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	723,087	7,519,574	0.096161	825,086	79,341	52.00
53.00	05300 ANESTHESIOLOGY	430,941	4,886,161	0.088196	314,514	27,739	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	4,556,054	35,662,381	0.127755	1,437,925	183,702	54.00
60.00	06000 LABORATORY	3,890,738	36,143,205	0.107648	1,507,276	162,255	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	264,609	7,108,301	0.037225	673,631	25,076	62.00
64.00	06400 INTRAVENOUS THERAPY	423,028	2,403,696	0.175991	167,588	29,494	64.00
65.00	06500 RESPIRATORY THERAPY	1,130,988	10,481,544	0.107903	1,123,671	121,247	65.00
66.00	06600 PHYSICAL THERAPY	257,475	3,018,396	0.085302	144,602	12,335	66.00
67.00	06700 OCCUPATIONAL THERAPY	191,535	1,195,294	0.160241	39,830	6,382	67.00
68.00	06800 SPEECH PATHOLOGY	125,664	1,129,308	0.111275	16,414	1,826	68.00
69.00	06900 ELECTROCARDIOLOGY	1,342,271	9,012,297	0.148938	176,541	26,294	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	3,313,528	42,275,653	0.078379	2,974,957	233,174	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	118,003	5,406,336	0.021827	385,567	8,416	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	3,169,950	93,180,854	0.034019	4,021,543	136,809	73.00
74.00	07400 RENAL DIALYSIS	281,065	5,773,147	0.048685	318,018	15,483	74.00
76.00	03950 WAIVER PURCHASED PATIENT SERVICES	0	0	0.000000	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	10,747,388	102,734,914	0.104613	0	0	90.00
91.00	09100 EMERGENCY	4,567,133	52,406,598	0.087148	346,451	30,193	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	499,254	4,203,114	0.118782	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
98.00	05950 OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0	0	98.00
200.00	Total (lines 50-199)	41,491,097	472,746,693		17,576,551	1,451,114	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 140124		Period: From 12/01/2011 To 11/30/2012		Worksheet D Part III Date/Time Prepared: 4/30/2013 10:17 am	
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Hospital	PPS	
			1.00	2.00	3.00	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
						4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
33.00	03300	BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT	0	0	0	0	0	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT	0	0	0	0	0	34.02
34.03	02060	NEURO INTENSIVE CARE UNIT	0	0	0	0	0	34.03
34.04	02061	NEONATAL INTENSIVE CARE UNIT	0	0	0	0	0	34.04
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 140124		Period: From 12/01/2011 To 11/30/2012		Worksheet D Part III Date/Time Prepared: 4/30/2013 10:17 am	
Cost Center Description		Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. Nursing School	PPS
		6.00	7.00	8.00	9.00	11.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	84,041	0.00	9,821	0	0	30.00
31.00	03100 INTENSIVE CARE UNIT	7,775	0.00	1,024	0	0	31.00
33.00	03300 BURN INTENSIVE CARE UNIT	1,281	0.00	169	0	0	33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	2,789	0.00	367	0	0	34.00
34.01	02080 PEDIATRIC INTENSIVE CARE UNIT	1,136	0.00	0	0	0	34.01
34.02	02180 TRAUMA INTENSIVE CARE UNIT	2,871	0.00	378	0	0	34.02
34.03	02060 NEURO INTENSIVE CARE UNIT	2,206	0.00	291	0	0	34.03
34.04	02061 NEONATAL INTENSIVE CARE UNIT	9,609	0.00	0	0	0	34.04
43.00	04300 NURSERY	1,859	0.00	0	0	0	43.00
200.00	Total (lines 30-199)	113,567		12,050	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140124	Period: From 12/01/2011 To 11/30/2012	Worksheet D Part III Date/Time Prepared: 4/30/2013 10:17 am
Title XVIII		Hospital	PPS

Cost Center Description	PSA Adj . Allied Health Cost	PSA Adj . All Other Medical Education Cost		
	12.00	13.00		
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00 03000 ADULTS & PEDIATRICS	0	0		30.00
31.00 03100 INTENSIVE CARE UNIT	0	0		31.00
33.00 03300 BURN INTENSIVE CARE UNIT	0	0		33.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0	0		34.00
34.01 02080 PEDIATRIC INTENSIVE CARE UNIT	0	0		34.01
34.02 02180 TRAUMA INTENSIVE CARE UNIT	0	0		34.02
34.03 02060 NEURO INTENSIVE CARE UNIT	0	0		34.03
34.04 02061 NEONATAL INTENSIVE CARE UNIT	0	0		34.04
43.00 04300 NURSERY	0	0		43.00
200.00 Total (lines 30-199)	0	0		200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140124

Period:
From 12/01/2011
To 11/30/2012

Worksheet D
Part IV
Date/Time Prepared:
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Cost Center Description		Title XVIII				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	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	0	0	54.00
60.00	06000	LABORATORY	0	0	0	0	0	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	0	62.00
64.00	06400	INTRAVENOUS THERAPY	0	0	0	0	0	0	64.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	316,665	0	316,665	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	0	74.00
76.00	03950	WAI VER PURCHASED PATIENT SERVICES	0	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS									
90.00	09000	CLINIC	0	0	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS									
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	0	98.00
200.00		Total (lines 50-199)	0	0	316,665	0	316,665	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140124

Period:
From 12/01/2011
To 11/30/2012

Worksheet D
Part IV
Date/Time Prepared:
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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)	Hospital		Inpatient Program Charges	
					Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	PPS		
		6.00	7.00	8.00	9.00	10.00		
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	0	42,536,089	0.000000	0.000000	2,737,979	50.00
51.00	05100	RECOVERY ROOM	0	5,669,831	0.000000	0.000000	364,958	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	7,519,574	0.000000	0.000000	825,086	52.00
53.00	05300	ANESTHESIOLOGY	0	4,886,161	0.000000	0.000000	314,514	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	35,662,381	0.000000	0.000000	1,437,925	54.00
60.00	06000	LABORATORY	0	36,143,205	0.000000	0.000000	1,507,276	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	0	7,108,301	0.000000	0.000000	673,631	62.00
64.00	06400	INTRAVENOUS THERAPY	0	2,403,696	0.000000	0.000000	167,588	64.00
65.00	06500	RESPIRATORY THERAPY	0	10,481,544	0.000000	0.000000	1,123,671	65.00
66.00	06600	PHYSICAL THERAPY	0	3,018,396	0.000000	0.000000	144,602	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	1,195,294	0.000000	0.000000	39,830	67.00
68.00	06800	SPEECH PATHOLOGY	0	1,129,308	0.000000	0.000000	16,414	68.00
69.00	06900	ELECTROCARDIOLOGY	0	9,012,297	0.000000	0.000000	176,541	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	42,275,653	0.000000	0.000000	2,974,957	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	5,406,336	0.000000	0.000000	385,567	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	316,665	93,180,854	0.003398	0.003398	4,021,543	73.00
74.00	07400	RENAL DIALYSIS	0	5,773,147	0.000000	0.000000	318,018	74.00
76.00	03950	WAIWER PURCHASED PATIENT SERVICES	0	0	0.000000	0.000000	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0	102,734,914	0.000000	0.000000	0	90.00
91.00	09100	EMERGENCY	0	52,406,598	0.000000	0.000000	346,451	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0	4,203,114	0.000000	0.000000	0	92.00
OTHER REIMBURSABLE COST CENTERS								
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0	0	0.000000	0.000000	0	98.00
200.00		Total (lines 50-199)	316,665	472,746,693			17,576,551	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140124

Period:
From 12/01/2011
To 11/30/2012

Worksheet D
Part IV
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Cost Center Description		Title XVIII			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	1,202,213	0	0	0	50.00
51.00	05100 RECOVERY ROOM	0	219,983	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0	939,833	0	0	0	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	8,142,383	0	0	0	54.00
60.00	06000 LABORATORY	0	441,752	0	0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	10,921	0	0	0	62.00
64.00	06400 INTRAVENOUS THERAPY	0	310,327	0	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	163,782	0	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	0	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	4,354	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	36,496	0	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	502,434	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	53,100	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	203,236	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	13,665	3,684,628	12,520	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
76.00	03950 WAIVER PURCHASED PATIENT SERVICES	0	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLINIC	0	14,557,179	0	0	0	90.00
91.00	09100 EMERGENCY	0	2,551,915	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	965,310	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS							
98.00	05950 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
200.00	Total (lines 50-199)	13,665	33,989,846	12,520	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140124

Period:
From 12/01/2011
To 11/30/2012

Worksheet D
Part IV
Date/Time Prepared:
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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
60.00	06000 LABORATORY	0	0		60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		62.00
64.00	06400 INTRAVENOUS THERAPY	0	0		64.00
65.00	06500 RESPIRATORY THERAPY	0	0		65.00
66.00	06600 PHYSICAL THERAPY	0	0		66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0		67.00
68.00	06800 SPEECH PATHOLOGY	0	0		68.00
69.00	06900 ELECTROCARDIOLOGY	0	0		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO 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
76.00	03950 WAIVER PURCHASED PATIENT SERVICES	0	0		76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0	0		90.00
91.00	09100 EMERGENCY	0	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		92.00
OTHER REIMBURSABLE COST CENTERS					
98.00	05950 OTHER REIMBURSABLE COST CENTERS	0	0		98.00
200.00	Total (lines 50-199)	0	0		200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 140124

Period:
From 12/01/2011
To 11/30/2012

Worksheet D
Part V
Date/Time Prepared:
4/30/2013 10:17 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	0.964504	1,202,213	0	0	1,159,539	50.00
51.00	05100	RECOVERY ROOM	1.000000	219,983	0	0	219,983	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.000000	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0.733059	939,833	0	0	688,953	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.988912	8,142,383	0	0	8,052,100	54.00
60.00	06000	LABORATORY	0.990643	441,752	0	0	437,619	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1.000000	10,921	0	0	10,921	62.00
64.00	06400	INTRAVENOUS THERAPY	1.000000	310,327	0	0	310,327	64.00
65.00	06500	RESPIRATORY THERAPY	0.978678	163,782	0	0	160,290	65.00
66.00	06600	PHYSICAL THERAPY	1.000000	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1.000000	4,354	0	0	4,354	67.00
68.00	06800	SPEECH PATHOLOGY	1.000000	36,496	0	0	36,496	68.00
69.00	06900	ELECTROCARDIOLOGY	0.965716	502,434	0	0	485,209	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.000000	53,100	0	0	53,100	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.000000	203,236	0	0	203,236	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1.000000	3,684,628	0	21,988	3,684,628	73.00
74.00	07400	RENAL DIALYSIS	1.000000	0	0	0	0	74.00
76.00	03950	WAIVER PURCHASED PATIENT SERVICES	0.000000	0	0	0	0	76.00
OUTPATIENT SERVICE COST CENTERS								
90.00	09000	CLINIC	0.985955	14,557,179	0	148	14,352,723	90.00
91.00	09100	EMERGENCY	0.963801	2,551,915	0	0	2,459,538	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART	0.845561	965,310	0	0	816,228	92.00
OTHER REIMBURSABLE COST CENTERS								
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0.000000	0	0	0	0	98.00
200.00		Subtotal (see instructions)		33,989,846	0	22,136	33,135,244	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges			0	0		201.00
202.00		Net Charges (line 200 +/- line 201)		33,989,846	0	22,136	33,135,244	202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 140124	Period: From 12/01/2011 To 11/30/2012	Worksheet D Part V Date/Time Prepared: 4/30/2013 10:17 am
	Title XVIII	Hospital	PPS

Cost Center Description	Costs			
	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)		
	6.00	7.00		
ANCILLARY SERVICE COST CENTERS				
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
60.00	06000 LABORATORY	0	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	62.00
64.00	06400 INTRAVENOUS THERAPY	0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0	0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO 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	21,988	73.00
74.00	07400 RENAL DIALYSIS	0	0	74.00
76.00	03950 WAIVER PURCHASED PATIENT SERVICES	0	0	76.00
OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLINIC	0	146	90.00
91.00	09100 EMERGENCY	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	92.00
OTHER REIMBURSABLE COST CENTERS				
98.00	05950 OTHER REIMBURSABLE COST CENTERS	0	0	98.00
200.00	Subtotal (see instructions)	0	22,134	200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00	Net Charges (line 200 +/- line 201)	0	22,134	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140124	Period: From 12/01/2011 To 11/30/2012	Worksheet D-1 Date/Time Prepared: 4/30/2013 10:17 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)		84,041	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		84,041	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)		81,539	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)		9,821	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)		119,376,653	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)		119,376,653	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		141,136,272	28.00
29.00	Private room charges (excluding swing-bed charges)		62,546,418	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		78,589,854	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.845825	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)		963.83	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)		119,376,653	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)		1,420.46	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		13,950,338	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)		13,950,338	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 140124	Period: From 12/01/2011 To 11/30/2012	Worksheet D-1 Date/Time Prepared: 4/30/2013 10:17 am	
Title XVIII			Hospital		PPS	
Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00 NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
Intensive Care Type Inpatient Hospital Units						
43.00 INTENSIVE CARE UNIT	17,713,533	7,775	2,278.27	1,024	2,332,948	43.00
44.00 CORONARY CARE UNIT						44.00
45.00 BURN INTENSIVE CARE UNIT	3,917,559	1,281	3,058.20	169	516,836	45.00
46.00 SURGICAL INTENSIVE CARE UNIT	6,971,512	2,789	2,499.65	367	917,372	46.00
46.01 PEDIATRIC INTENSIVE CARE UNIT	4,301,908	1,136	3,786.89	0	0	46.01
46.02 TRAUMA INTENSIVE CARE UNIT	13,648,925	2,871	4,754.07	378	1,797,038	46.02
46.03 NEURO INTENSIVE CARE UNIT	4,813,312	2,206	2,181.92	291	634,939	46.03
46.04 NEONATAL INTENSIVE CARE UNIT	15,467,058	9,609	1,609.64	0	0	46.04
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)					17,576,551	48.00
49.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions)					37,726,022	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)					2,492,315	50.00
51.00 Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)					1,464,779	51.00
52.00 Total Program excludable cost (sum of lines 50 and 51)					3,957,094	52.00
53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					33,768,928	53.00
TARGET AMOUNT AND LIMIT COMPUTATION						
54.00 Program discharges					0	54.00
55.00 Target amount per discharge					0.00	55.00
56.00 Target amount (line 54 x line 55)					0	56.00
57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00 Bonus payment (see instructions)					0	58.00
59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00 Relief payment (see instructions)					0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00 Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00 Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00 Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00 Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY						
70.00 Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)						70.00
71.00 Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00 Program routine service cost (line 9 x line 71)						72.00
73.00 Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00 Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00 Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00 Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00 Program capital-related costs (line 9 x line 76)						77.00
78.00 Inpatient routine service cost (line 74 minus line 77)						78.00
79.00 Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00 Inpatient routine service cost per diem limitation						81.00
82.00 Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00 Reasonable inpatient routine service costs (see instructions)						83.00
84.00 Program inpatient ancillary services (see instructions)						84.00
85.00 Utilization review - physician compensation (see instructions)						85.00
86.00 Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST						
87.00 Total observation bed days (see instructions)					2,502	87.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,420.46	88.00
89.00 Observation bed cost (line 87 x line 88) (see instructions)					3,553,991	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140124		Period: From 12/01/2011 To 11/30/2012		Worksheet D-1 Date/Time Prepared: 4/30/2013 10:17 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	16,769,702	119,376,653	0.140477	3,553,991	499,254	90.00
91.00	Nursing School cost	0	119,376,653	0.000000	3,553,991	0	91.00
92.00	Allied health cost	0	119,376,653	0.000000	3,553,991	0	92.00
93.00	All other Medical Education	0	119,376,653	0.000000	3,553,991	0	93.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140124	Period: From 12/01/2011 To 11/30/2012	Worksheet D-1
		Title XIX	Hospital	Date/Time Prepared: 4/30/2013 10:17 am
Cost Center Description			Cost	
			1.00	
PART I - ALL PROVIDER COMPONENTS				
INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		84,041	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		84,041	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)		81,539	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)		27,057	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)		1,859	15.00
16.00	Nursery days (title V or XIX only)		1,671	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)		115,185,745	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)		115,185,745	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		141,136,272	28.00
29.00	Private room charges (excluding swing-bed charges)		62,546,418	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		78,589,854	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.816131	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)		963.83	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)		115,185,745	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)		1,370.59	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		37,084,054	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)		37,084,054	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 140124	Period: From 12/01/2011 To 11/30/2012	Worksheet D-1 Date/Time Prepared: 4/30/2013 10:17 am		
Cost Center Description			Title XIX		Hospital Cost		
	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)	4,921,758	1,859	2,647.53	1,671	4,424,023	42.00
Intensive Care Type Inpatient Hospital Units							
43.00	INTENSIVE CARE UNIT	17,508,237	7,775	2,251.86	3,684	8,295,852	43.00
44.00	CORONARY CARE UNIT						44.00
45.00	BURN INTENSIVE CARE UNIT	3,753,080	1,281	2,929.80	543	1,590,881	45.00
46.00	SURGICAL INTENSIVE CARE UNIT	6,954,735	2,789	2,493.63	954	2,378,923	46.00
46.01	PEDIATRIC INTENSIVE CARE UNIT	4,198,378	1,136	3,695.76	766	2,830,952	46.01
46.02	TRAUMA INTENSIVE CARE UNIT	13,522,397	2,871	4,710.00	1,108	5,218,680	46.02
46.03	NEURO INTENSIVE CARE UNIT	4,744,906	2,206	2,150.91	168	361,353	46.03
46.04	NEONATAL INTENSIVE CARE UNIT	15,210,594	9,609	1,582.95	9,369	14,830,659	46.04
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)					77,015,377	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)					0	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)					0	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)					0	53.00
TARGET AMOUNT AND LIMIT COMPUTATION							
54.00	Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
57.00	Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)					0	57.00
58.00	Bonus payment (see instructions)					0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket					0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket					0.00	60.00
61.00	If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)					0	61.00
62.00	Relief payment (see instructions)					0	62.00
63.00	Allowable Inpatient cost plus incentive payment (see instructions)					0	63.00
PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions)(title XVIII only)					0	64.00
65.00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)					0	65.00
66.00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)					0	66.00
67.00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)					0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68.00
69.00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69.00
PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY							
70.00	Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)						70.00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)						71.00
72.00	Program routine service cost (line 9 x line 71)						72.00
73.00	Medically necessary private room cost applicable to Program (line 14 x line 35)						73.00
74.00	Total Program general inpatient routine service costs (line 72 + line 73)						74.00
75.00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)						75.00
76.00	Per diem capital-related costs (line 75 ÷ line 2)						76.00
77.00	Program capital-related costs (line 9 x line 76)						77.00
78.00	Inpatient routine service cost (line 74 minus line 77)						78.00
79.00	Aggregate charges to beneficiaries for excess costs (from provider records)						79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limitation						81.00
82.00	Inpatient routine service cost limitation (line 9 x line 81)						82.00
83.00	Reasonable inpatient routine service costs (see instructions)						83.00
84.00	Program inpatient ancillary services (see instructions)						84.00
85.00	Utilization review - physician compensation (see instructions)						85.00
86.00	Total Program inpatient operating costs (sum of lines 83 through 85)						86.00
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
87.00	Total observation bed days (see instructions)					2,502	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)					1,370.59	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)					3,429,216	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140124		Period: From 12/01/2011 To 11/30/2012		Worksheet D-1 Date/Time Prepared: 4/30/2013 10:17 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	0	0	0.000000	0	0	90.00
91.00	Nursing School cost	0	0	0.000000	0	0	91.00
92.00	Allied health cost	0	0	0.000000	0	0	92.00
93.00	All other Medical Education	0	0	0.000000	0	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140124	Period: From 12/01/2011 To 11/30/2012	Worksheet D-3 Date/Time Prepared: 4/30/2013 10:17 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		16,830,945	30.00
31.00	03100	INTENSIVE CARE UNIT		2,230,272	31.00
33.00	03300	BURN INTENSIVE CARE UNIT		368,082	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		799,326	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT		0	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT		823,284	34.02
34.03	02060	NEURO INTENSIVE CARE UNIT		633,798	34.03
34.04	02061	NEONATAL INTENSIVE CARE UNIT		0	34.04
43.00	04300	NURSERY		0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	1.000000	2,737,979	50.00
51.00	05100	RECOVERY ROOM	1.000000	364,958	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.000000	825,086	52.00
53.00	05300	ANESTHESIOLOGY	1.000000	314,514	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	1.000000	1,437,925	54.00
60.00	06000	LABORATORY	1.000000	1,507,276	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1.000000	673,631	62.00
64.00	06400	INTRAVENOUS THERAPY	1.000000	167,588	64.00
65.00	06500	RESPIRATORY THERAPY	1.000000	1,123,671	65.00
66.00	06600	PHYSICAL THERAPY	1.000000	144,602	66.00
67.00	06700	OCCUPATIONAL THERAPY	1.000000	39,830	67.00
68.00	06800	SPEECH PATHOLOGY	1.000000	16,414	68.00
69.00	06900	ELECTROCARDIOLOGY	1.000000	176,541	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.000000	2,974,957	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.000000	385,567	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1.000000	4,021,543	73.00
74.00	07400	RENAL DIALYSIS	1.000000	318,018	74.00
76.00	03950	WAIVER PURCHASED PATIENT SERVICES	0.000000	0	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	1.000000	0	90.00
91.00	09100	EMERGENCY	1.000000	346,451	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.845561	0	92.00
OTHER REIMBURSABLE COST CENTERS					
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0.000000	0	98.00
200.00		Total (sum of lines 50-94 and 96-98)		17,576,551	200.00
201.00		Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	201.00
202.00		Net Charges (line 200 minus line 201)		17,576,551	202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140124	Period: From 12/01/2011 To 11/30/2012	Worksheet D-3 Date/Time Prepared: 4/30/2013 10:17 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		46,372,929	30.00
31.00	03100	INTENSIVE CARE UNIT		8,023,752	31.00
33.00	03300	BURN INTENSIVE CARE UNIT		1,178,298	33.00
34.00	03400	SURGICAL INTENSIVE CARE UNIT		2,077,812	34.00
34.01	02080	PEDIATRIC INTENSIVE CARE UNIT		1,668,348	34.01
34.02	02180	TRAUMA INTENSIVE CARE UNIT		2,413,224	34.02
34.03	02060	NEURO INTENSIVE CARE UNIT		365,904	34.03
34.04	02061	NEONATAL INTENSIVE CARE UNIT		20,405,682	34.04
43.00	04300	NURSERY		641,664	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	0.964504	0	50.00
51.00	05100	RECOVERY ROOM	1.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	1.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0.733059	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0.988912	0	54.00
60.00	06000	LABORATORY	0.990643	0	60.00
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELL	1.000000	0	62.00
64.00	06400	INTRAVENOUS THERAPY	1.000000	0	64.00
65.00	06500	RESPIRATORY THERAPY	0.978678	0	65.00
66.00	06600	PHYSICAL THERAPY	1.000000	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	1.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	1.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0.965716	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	1.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	1.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	1.000000	0	73.00
74.00	07400	RENAL DIALYSIS	1.000000	0	74.00
76.00	03950	WAIVER PURCHASED PATIENT SERVICES	0.000000	0	76.00
OUTPATIENT SERVICE COST CENTERS					
90.00	09000	CLINIC	0.985955	0	90.00
91.00	09100	EMERGENCY	0.963801	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0.845561	0	92.00
OTHER REIMBURSABLE COST CENTERS					
98.00	05950	OTHER REIMBURSABLE COST CENTERS	0.000000	0	98.00
200.00		Total (sum of lines 50-94 and 96-98)		0	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)		0	202.00

APPORTIONMENT OF COST FOR THE SERVICES OF TEACHING PHYSICIANS
REASONABLE COMPENSATION EQUIVALENT COMPUTATION

Provider CCN: 140124

Period:
From 12/01/2011
To 11/30/2012

Worksheet D-5
Part I
Date/Time Prepared:
4/30/2013 10:17 am

Cost Center Description	Hospital Staff			Hospital		PPS	
	Total Remuneration	Professional Component	RCE Amount	Physician/Professional Component Hours	Unadjusted RCE Limit		
	3.00	4.00	5.00	6.00	7.00		
1.00 General Practitioner Family Practice	0	0	0	0	0	0	1.00
2.00 Internal Medicine	0	0	0	0	0	0	2.00
3.00 Surgery	0	0	0	0	0	0	3.00
4.00 Pediatrics	0	0	0	0	0	0	4.00
5.00 Obstetrics-Gynecology	0	0	0	0	0	0	5.00
6.00 Radiology	0	0	0	0	0	0	6.00
7.00 Psychiatry	0	0	0	0	0	0	7.00
8.00 Anesthesiology	0	0	0	0	0	0	8.00
9.00 Pathology	0	0	0	0	0	0	9.00
10.00 All Other	0	0	0	0	0	0	10.00
11.00 Total	0	0	0	0	0	0	11.00

APPORTIONMENT OF COST FOR THE SERVICES OF TEACHING PHYSICIANS
 REASONABLE COMPENSATION EQUIVALENT COMPUTATION

Provider CCN: 140124

Period:
 From 12/01/2011
 To 11/30/2012

Worksheet D-5
 Part I
 Date/Time Prepared:
 4/30/2013 10:17 am

Cost Center Description	Hospital Staff		Hospital		PPS	
	5 Percent of Unadjusted RCE Limit	Cost of Memberships & Continuing Education	Provider Component Share of col. 11	Cost of Physician Malpractice Insurance	Professional Component Share of col. 13	
	8.00	11.00	12.00	13.00	14.00	
1.00 General Practitioner Family Practice	0	0	0	0	0	1.00
2.00 Internal Medicine	0	0	0	0	0	2.00
3.00 Surgery	0	0	0	0	0	3.00
4.00 Pediatrics	0	0	0	0	0	4.00
5.00 Obstetrics-Gynecology	0	0	0	0	0	5.00
6.00 Radiology	0	0	0	0	0	6.00
7.00 Psychiatry	0	0	0	0	0	7.00
8.00 Anesthesiology	0	0	0	0	0	8.00
9.00 Pathology	0	0	0	0	0	9.00
10.00 All Other	0	0	0	0	0	10.00
11.00 Total	0	0	0	0	0	11.00

APPORTIONMENT OF COST FOR THE SERVICES OF TEACHING PHYSICIANS
REASONABLE COMPENSATION EQUIVALENT COMPUTATION

Provider CCN: 140124

Period:
From 12/01/2011
To 11/30/2012

Worksheet D-5
Part I
Date/Time Prepared:
4/30/2013 10:17 am

Cost Center Description		Hospital Staff		Hospital	PPS
		Adjusted RCE Limit	Adjust Cost of Physician's Direct Medical & Surgical Services		
		15.00	16.00		
1.00	General Practitioner Family Practice	0	0		1.00
2.00	Internal Medicine	0	0		2.00
3.00	Surgery	0	0		3.00
4.00	Pediatrics	0	0		4.00
5.00	Obstetrics-Gynecology	0	0		5.00
6.00	Radiology	0	0		6.00
7.00	Psychiatry	0	0		7.00
8.00	Anesthesiology	0	0		8.00
9.00	Pathology	0	0		9.00
10.00	All Other	0	0		10.00
11.00	Total	0	0		11.00

APPORTIONMENT OF COST FOR THE SERVICES OF TEACHING PHYSICIANS		Provider CCN: 140124	Period: From 12/01/2011 To 11/30/2012	Worksheet D-5 Part II Date/Time Prepared: 4/30/2013 10:17 am
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Cost Center Description		Hospital		PPS	
		Hospital Staff	Medical School Faculty	Total (col 1 + col 2)	
		1.00	2.00	3.00	
1.00	Adjusted Cost of Physician's Direct Medical and Surgical Services	0	0		1.00
2.00	Total Inpatient Days and Outpatient Visit Days	0	0		2.00
3.00	Average Per Diem (line 1 ÷ line 2)	0.00	0.00		3.00
Health Care Program Reimbursable Days					
4.00	Title V - Inpatient	0	0		4.00
5.00	Title V - Outpatient	0	0		5.00
6.00	Title XVIII - Part A	0	0		6.00
7.00	Title XVIII - Part B	0	0		7.00
8.00	Title XIX - Inpatient	0	0		8.00
9.00	Title XIX - Outpatient	0	0		9.00
10.00	Inpatient and Outpatient Kidney Acquisition	0	0		10.00
11.00	Inpatient and Outpatient Liver Acquisition	0	0		11.00
12.00	Inpatient and Outpatient Heart Acquisition	0	0		12.00
13.00	Inpatient and Outpatient Lung Acquisition	0	0		13.00
14.00	Inpatient and Outpatient Pancreas Acquisition	0	0		14.00
15.00	Inpatient and Outpatient Intestine Acquisition	0	0		15.00
16.00	Inpatient and Outpatient Islet Acquisition	0	0		16.00
17.00	OTHER ORGAN ACQUISITION	0	0		17.00
Health Care Program Reimbursable Cost					
18.00	Title V - Inpatient (line 3 x line 4)	0	0	0	18.00
19.00	Title V - Outpatient (line 3 x line 5)	0	0	0	19.00
20.00	Title XVIII - Part A (line 3 x line 6)	0	0	0	20.00
21.00	Title XVIII - Part B (line 3 x line 7)	0	0	0	21.00
22.00	Title XIX - Inpatient (line 3 x line 8)	0	0	0	22.00
23.00	Title XIX - Outpatient (line 3 x line 9)	0	0	0	23.00
24.00	Inpatient and Outpatient Kidney Acquisition (line 3 x line 10)	0	0	0	24.00
25.00	Inpatient and Outpatient Liver Acquisition (line 3 x line 11)	0	0	0	25.00
26.00	Inpatient and Outpatient Heart Acquisition (line 3 x line 12)	0	0	0	26.00
27.00	Inpatient and Outpatient Lung Acquisition (line 3 x line 13)	0	0	0	27.00
28.00	Inpatient and Outpatient Pancreas Acquisition (line 3 x line 14)	0	0	0	28.00
29.00	Inpatient and Outpatient Intestine Acquisition (line 3 x line 15)	0	0	0	29.00
30.00	Inpatient and Outpatient Islet Acquisition (line 3 x line 16)	0	0	0	30.00
31.00	Inpatient and Outpatient Other Organ Acquisition (line 3 x line 17)	0	0	0	31.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140124	Period: From 12/01/2011 To 11/30/2012	Worksheet E Part A Date/Time Prepared: 4/30/2013 10:17 am
		Title XVIII	Hospital	PPS
			before 1/1	on/after 1/1
			1.00	1.01
PART A - INPATIENT HOSPITAL SERVICES UNDER PPS				
1.00	DRG Amounts Other than Outlier Payments		18,045,428	1.00
2.00	Outlier payments for discharges. (see instructions)		1,973,784	2.00
2.01	Outlier reconciliation amount		0	2.01
3.00	Managed Care Simulated Payments		1,138,476	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		453.16	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)		522.08	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)		36.60	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 Federal Register, page 50069, August 1, 2002.		-85.00	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)		400.48	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		442.80	10.00
11.00	FTE count for residents in dental and podiatric programs.		11.50	11.00
12.00	Current year allowable FTE (see instructions)		411.98	12.00
13.00	Total allowable FTE count for the prior year.		409.95	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.		411.03	14.00
15.00	Sum of lines 12 through 14 divided by 3.		410.99	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		410.99	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.906942	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.900474	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.900474	21.00
22.00	IME payment adjustment (see instructions)		7,691,710	22.00
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)		42.32	24.00
25.00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment. (see instructions)		0.000000	27.00
28.00	IME Adjustment (see instructions)		0	28.00
29.00	Total IME payment (sum of lines 22 and 28)		7,691,710	29.00
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		13.22	30.00
31.00	Percentage of Medicaid patient days to total days reported on Worksheet S-2, Part I, line 24. (see instructions)		46.83	31.00
32.00	Sum of lines 30 and 31		60.05	32.00
33.00	Allowable disproportionate share percentage (see instructions)		38.76	33.00
34.00	Disproportionate share adjustment (see instructions)		6,994,408	34.00
Additional payment for high percentage of ESRD beneficiary discharges				
40.00	Total Medicare discharges on Worksheet S-3, Part I excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)		0	40.00
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	41.00
42.00	Divide line 41 by line 40 (if less than 10%, you do not qualify for adjustment)		0.00	42.00
43.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 683, 684 and 685. (see instructions)		0	43.00
44.00	Ratio of average length of stay to one week (line 43 divided by line 41 divided by 7 days)		0.000000	44.00
45.00	Average weekly cost for dialysis treatments (see instructions)		0.00	45.00
46.00	Total additional payment (line 45 times line 44 times line 41)		0	46.00
47.00	Subtotal (see instructions)		34,705,330	47.00
48.00	Hospital specific payments (to be completed by SCH and MDH, small rural hospitals only. (see instructions)		0	48.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140124	Period: From 12/01/2011 To 11/30/2012	Worksheet E Part A Date/Time Prepared: 4/30/2013 10:17 am
		Title XVIII	Hospital	PPS
			before 1/1	on/after 1/1
			1.00	1.01
49.00	Total payment for inpatient operating costs SCH and MDH only (see instructions)		34,705,330	49.00
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)		2,660,528	50.00
51.00	Exception payment for inpatient program capital (Worksheet L, Part III, see instructions)		0	51.00
52.00	Direct graduate medical education payment (from Worksheet E-4, line 49 see instructions).		2,055,480	52.00
53.00	Nursing and Allied Health Managed Care payment		0	53.00
54.00	Special add-on payments for new technologies		0	54.00
55.00	Net organ acquisition cost (Worksheet D-4 Part III, col. 1, line 69)		0	55.00
56.00	Cost of teaching physicians (Worksheet D-5, Part II, col. 3, line 20)		0	56.00
57.00	Routine service other pass through costs (from Wkst D, Part III, column 9, lines 30-35).		0	57.00
58.00	Ancillary service other pass through costs Worksheet D, Part IV, col. 11 line 200)		13,665	58.00
59.00	Total (sum of amounts on lines 49 through 58)		39,435,003	59.00
60.00	Primary payer payments		0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		39,435,003	61.00
62.00	Deductibles billed to program beneficiaries		1,999,895	62.00
63.00	Coinsurance billed to program beneficiaries		87,036	63.00
64.00	Allowable bad debts (see instructions)		405,776	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		284,043	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		274,392	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		37,632,115	67.00
68.00	Credits received from manufacturers for replaced devices applicable to MS-DRG (see instructions)		0	68.00
69.00	Outlier payments reconciliation (Sum of lines 93, 95 and 96). (For SCH see instructions)		0	69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	70.00
70.93	HVBP incentive payment (see instructions)		-5,213	70.93
70.94	Hospital readmissions reduction adjustment (see instructions)		-12,499	70.94
70.95	Recovery of Accelerated Depreciation		0	70.95
70.96	Low Volume Payment-1		0	70.96
70.97	Low Volume Payment-2		0	70.97
70.98	Low Volume Payment-3		0	70.98
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		37,614,403	71.00
72.00	Interim payments		36,519,961	72.00
73.00	Tentative settlement (for contractor use only)		0	73.00
74.00	Balance due provider (Program) (line 71 minus the sum of lines 72 and 73)		1,094,442	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		602,719	75.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Operating outlier amount from Worksheet E, Part A line 2 (see instructions)		0	90.00
91.00	Capital outlier from Worksheet L, Part I, line 2		0	91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)		0	93.00
94.00	The rate used to calculate the Time Value of Money		0.00	94.00
95.00	Time Value of Money for operating expenses(see instructions)		0	95.00
96.00	Time Value of Money for capital related expenses (see instructions)		0	96.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140124	Period: From 12/01/2011 To 11/30/2012	Worksheet E Part B Date/Time Prepared: 4/30/2013 10:17 am
		Title XVIII	Hospital	PPS
				1.00
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		22,134	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		33,122,724	2.00
3.00	PPS payments		11,338,005	3.00
4.00	Outlier payment (see instructions)		2,849,412	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00	Line 2 times line 5		0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6		0.00	7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Worksheet D, Part IV, column 13, line 200		12,520	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		22,134	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		22,136	12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		22,136	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)		22,136	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		2	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)		22,134	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)		14,199,937	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		3,350,537	26.00
27.00	Subtotal {(lines 21 and 24 - the sum of lines 25 and 26) plus the sum of lines 22 and 23} (for CAH, see instructions)		10,871,534	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)		1,806,564	28.00
29.00	ESRD direct medical education costs (from Worksheet E-4, line 36)		0	29.00
30.00	Subtotal (sum of lines 27 through 29)		12,678,098	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		12,678,098	32.00
ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33.00	Composite rate ESRD (from Worksheet I-5, line 11)		0	33.00
34.00	Allowable bad debts (see instructions)		110,664	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		77,465	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		110,664	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)		12,755,563	37.00
38.00	MSP-LCC reconciliation amount from PS&R		0	38.00
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.98	AB Re-billing demo amount (see instructions)		0	39.98
39.99	RECOVERY OF ACCELERATED DEPRECIATION		0	39.99
40.00	Subtotal (line 37 plus or minus lines 39 minus 38)		12,755,563	40.00
41.00	Interim payments		12,647,363	41.00
42.00	Tentative settlement (for contractors use only)		0	42.00
43.00	Balance due provider/program (line 40 minus the sum of lines 41, and 42)		108,200	43.00
44.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		0	44.00
TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)		0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)		0	91.00
92.00	The rate used to calculate the Time Value of Money		0.00	92.00
93.00	Time Value of Money (see instructions)		0	93.00
94.00	Total (sum of lines 91 and 93)		0	94.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140124	Period: From 12/01/2011 To 11/30/2012	Worksheet E Part B Date/Time Prepared: 4/30/2013 10:17 am
		Title XVIII	Hospital	PPS
				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: 140124

Period:
From 12/01/2011
To 11/30/2012

Worksheet E-1
Part I
Date/Time Prepared:
4/30/2013 10:17 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		36,590,908		12,541,165	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	07/13/2020	229,276	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	07/13/2012	63,060		0	3.50	
3.51		10/12/2012	7,887	10/12/2012	123,078	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		-70,947		106,198	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)		36,519,961		12,647,363	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		1,094,442		108,200	6.01	
6.02	SETTLEMENT TO PROGRAM		0		0	6.02	
7.00	Total Medicare program liability (see instructions)		37,614,403		12,755,563	7.00	
				Contractor Number	Date (Mo/Day/Yr)		
		0		1.00	2.00		
8.00	Name of Contractor					8.00	

CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT		Provider CCN: 140124	Period: From 12/01/2011 To 11/30/2012	Worksheet E-1 Part II Date/Time Prepared: 4/30/2013 10:17 am
		Title XVIII	Hospital	PPS
				1.00
TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS				
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst S-3, Part I column 15 line 14			23,847 1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12			12,050 2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6, line 2			750 3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12			109,206 4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200			674,855,547 5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20			282,982,842 6.00
7.00	CAH only - The reasonable cost incurred for the purchase of certified HIT technology Worksheet S-2, Part I line 168			0 7.00
8.00	Calculation of the HIT incentive payment (see instructions)			1,285,831 8.00
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			1,108,692 30.00
31.00	Other Adjustment (specify)			0 31.00
32.00	Balance due provider (line 8 minus line 30 and line 31)			177,139 32.00
				Overrides
				1.00
CONTRACTOR OVERRIDES				
108.00	Override of HIT payment			0 108.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140124	Period: From 12/01/2011 To 11/30/2012	Worksheet E-3 Part VII Date/Time Prepared: 4/30/2013 10:17 am	
		Title XIX	Hospital	Cost	
			Inpatient	Outpatient	
			1.00	2.00	
PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					
COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services		77,015,377		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		77,015,377	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		77,015,377	0	7.00
COMPUTATION OF LESSER OF COST OR CHARGES					
Reasonable Charges					
8.00	Routine service charges		0		8.00
9.00	Ancillary service charges		0	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		0	0	12.00
CUSTOMARY CHARGES					
13.00	Amount actually collected from patients liable for payment for services on a charge basis		0	0	13.00
14.00	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	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		0	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds line 4) (see instructions)		0	0	17.00
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions)		77,015,377	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of Teaching Physicians (see instructions)		0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		0	0	21.00
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.					
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	26.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		0	0	29.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT					
30.00	Excess of reasonable cost (from line 18)		77,015,377	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	0	31.00
32.00	Deductibles		0	0	32.00
33.00	Coinurance		0	0	33.00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		0	0	36.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37.00
38.00	Subtotal (line 36 ± line 37)		0	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	40.00
41.00	Interim payments		0	0	41.00
42.00	Balance due provider/program (line 40 minus 41)		0	0	42.00
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, section 115.2		0	0	43.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 140124	Period: From 12/01/2011 To 11/30/2012	Worksheet E-4 Date/Time Prepared: 4/30/2013 10:17 am	
		Title XVII I	Hospital	PPS	
				1.00	
COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			526.48	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			65.83	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			-60.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus line 4.01 plus line 4.02 plus applicable subscripts)			400.65	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			445.85	6.00
7.00	Enter the lesser of line 5 or line 6			400.65	7.00
		Primary Care	Other	Total	
		1.00	2.00	3.00	
8.00	Weighted FTE count for physicians in an allopathic and osteopathic program for the current year.	199.49	203.45	402.94	8.00
9.00	If line 6 is less than 5 enter the amount from line 8, otherwise multiply line 8 times the result of line 5 divided by the amount on line 6.	179.27	182.82	362.09	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		11.08		10.00
11.00	Total weighted FTE count	179.27	193.90		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	178.38	182.99		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	167.36	190.26		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	175.00	189.05		14.00
15.00	Adjustment for residents in initial years of new programs	0.00	0.00		15.00
16.00	Adjustment for residents displaced by program or hospital closure	0.00	0.00		16.00
17.00	Adjusted rolling average FTE count	175.00	189.05		17.00
18.00	Per resident amount	91,667.63	90,891.51		18.00
19.00	Approved amount for resident costs	16,041,835	17,183,040	33,224,875	19.00
				1.00	
20.00	Additional unweighted allopathic and osteopathic direct GME FTE resident cap slots received under 42 Sec. 413.79(c)(4)			0.00	20.00
21.00	Direct GME FTE unweighted resident count over cap (see instructions)			45.20	21.00
22.00	Allowable additional direct GME FTE Resident Count (see instructions)			0.00	22.00
23.00	Enter the locally adjustment national average per resident amount (see instructions)			0.00	23.00
24.00	Multiply line 22 time line 23			0	24.00
25.00	Total direct GME amount (sum of lines 19 and 24)			33,224,875	25.00
		Inpatient Part A	Managed care		
		1.00	2.00	3.00	
COMPUTATION OF PROGRAM PATIENT LOAD					
26.00	Inpatient Days	12,050	750		26.00
27.00	Total Inpatient Days (see instructions)	109,206	109,206		27.00
28.00	Ratio of inpatient days to total inpatient days	0.110342	0.006868		28.00
29.00	Program direct GME amount	3,666,099	228,188		29.00
30.00	Reduction for direct GME payments for Medicare managed care		32,243		30.00
31.00	Net Program direct GME amount			3,862,044	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 140124	Period: From 12/01/2011 To 11/30/2012	Worksheet E-4 Date/Time Prepared: 4/30/2013 10:17 am
		Title XVIII	Hospital	PPS
				1.00
DIRECT MEDICAL EDUCATION COSTS FOR ESRD COMPOSITE RATE - TITLE XVIII ONLY (NURSING SCHOOL AND PARAMEDICAL EDUCATION COSTS)				
32.00	Renal dialysis direct medical education costs (from Worksheet B, Part I, sum of columns 20 and 23, lines 74 and 94)		0	32.00
33.00	Renal dialysis and home dialysis total charges (Worksheet C, Part I, column 8, sum of lines 74 and 94)		5,773,147	33.00
34.00	Ratio of direct medical education costs to total charges (line 32 ÷ line 33)		0.000000	34.00
35.00	Medicare outpatient ESRD charges (see instructions)		0	35.00
36.00	Medicare outpatient ESRD direct medical education costs (line 34 x line 35)		0	36.00
APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII ONLY				
Part A Reasonable Cost				
37.00	Reasonable cost (see instructions)		37,726,022	37.00
38.00	Organ acquisition costs (Worksheet D-4, Part III, column 1, line 69)		0	38.00
39.00	Cost of teaching physicians (Worksheet D-5, Part II, column 3, line 20)		0	39.00
40.00	Primary payer payments (see instructions)		0	40.00
41.00	Total Part A reasonable cost (sum of lines 37 through 39 minus line 40)		37,726,022	41.00
Part B Reasonable Cost				
42.00	Reasonable cost (see instructions)		33,157,378	42.00
43.00	Primary payer payments (see instructions)		0	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)		33,157,378	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)		70,883,400	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)		0.532226	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)		0.467774	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48.00	Total program GME payment (line 31)		3,862,044	48.00
49.00	Part A Medicare GME payment (line 46 x 48)(Title XVIII only)(see instructions)		2,055,480	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)		1,806,564	50.00

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

Provider CCN: 140124

Period:
From 12/01/2011
To 11/30/2012

Worksheet G

Date/Time Prepared:
4/30/2013 10:17 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	653,051,743	0	0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes receivable	0	0	0	0	3.00
4.00	Accounts receivable	62,848,887	0	0	0	4.00
5.00	Other receivable	72,619,805	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6.00
7.00	Inventory	2,498,693	0	0	0	7.00
8.00	Prepaid expenses	0	0	0	0	8.00
9.00	Other current assets	0	0	0	0	9.00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	791,019,128	0	0	0	11.00
FIXED ASSETS						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	2,717,511	0	0	0	13.00
14.00	Accumulated depreciation	-1,539,284	0	0	0	14.00
15.00	Buildings	608,028,259	0	0	0	15.00
16.00	Accumulated depreciation	-240,915,576	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	19,718,463	0	0	0	19.00
20.00	Accumulated depreciation	-14,396,220	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	151,094,641	0	0	0	23.00
24.00	Accumulated depreciation	-124,676,099	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)	400,031,695	0	0	0	30.00
OTHER ASSETS						
31.00	Investments	0	0	0	0	31.00
32.00	Deposits on leases	0	0	0	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	0	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	0	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	1,191,050,823	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	17,922,547	0	0	0	37.00
38.00	Salaries, wages, and fees payable	45,189,617	0	0	0	38.00
39.00	Payroll taxes payable	0	0	0	0	39.00
40.00	Notes and loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	61,871,469	0	0	0	41.00
42.00	Accelerated payments	148,460,018	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	23,291	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	273,466,942	0	0	0	45.00
LONG TERM LIABILITIES						
46.00	Mortgage payable	0	0	0	0	46.00
47.00	Notes payable	0	0	0	0	47.00
48.00	Unsecured loans	0	0	0	0	48.00
49.00	Other long term liabilities	9,391,500	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	9,391,500	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	282,858,442	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	908,192,381				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)	908,192,381	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	1,191,050,823	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 140124

Period:
From 12/01/2011
To 11/30/2012

Worksheet G-1

Date/Time Prepared:
4/30/2013 10:17 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		460,638,473			0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		47,522,216				2.00
3.00	Total (sum of line 1 and line 2)		508,160,689			0	3.00
4.00	INVESTMENTS IN CAPITAL ASSESTS	400,031,695		0		0	4.00
5.00		0		0		0	5.00
6.00		0		0		0	6.00
7.00		0		0		0	7.00
8.00		0		0		0	8.00
9.00		0		0		0	9.00
10.00	Total additions (sum of line 4-9)		400,031,695			0	10.00
11.00	Subtotal (line 3 plus line 10)		908,192,384			0	11.00
12.00	ROUNDING	3		0		0	12.00
13.00		0		0		0	13.00
14.00		0		0		0	14.00
15.00		0		0		0	15.00
16.00		0		0		0	16.00
17.00		0		0		0	17.00
18.00	Total deductions (sum of lines 12-17)		3			0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		908,192,381			0	19.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 140124

Period:
From 12/01/2011
To 11/30/2012

Worksheet G-1

Date/Time Prepared:
4/30/2013 10:17 am

		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	INVESTMENTS IN CAPITAL ASSESTS				0			4.00
5.00					0			5.00
6.00					0			6.00
7.00					0			7.00
8.00					0			8.00
9.00					0			9.00
10.00	Total additions (sum of line 4-9)	0			0			10.00
11.00	Subtotal (line 3 plus line 10)	0			0			11.00
12.00	ROUNDING				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: 140124

Period:
From 12/01/2011
To 11/30/2012

Worksheet G-2
Parts I & II
Date/Time Prepared:
4/30/2013 10:17 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	141,850,128		141,850,128	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF				3.00
4.00	SUBPROVIDER				4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				7.00
8.00	NURSING FACILITY				8.00
9.00	OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	141,850,128		141,850,128	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	16,933,950		16,933,950	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT	2,790,018		2,790,018	13.00
14.00	SURGICAL INTENSIVE CARE UNIT	6,074,442		6,074,442	14.00
14.01	PEDIATRIC INTENSIVE CARE UNIT	2,474,208		2,474,208	14.01
14.02	TRAUMA INTENSIVE CARE UNIT	6,253,038		6,253,038	14.02
14.03	NEURO INTENSIVE CARE UNIT	4,804,668		4,804,668	14.03
14.04	NEONATAL INTENSIVE CARE UNIT	20,928,402		20,928,402	14.04
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	60,258,726		60,258,726	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	202,108,854		202,108,854	17.00
18.00	Ancillary services	218,049,378		218,049,378	18.00
19.00	Outpatient services	0	582,231,746	582,231,746	19.00
20.00	RURAL HEALTH CLINIC	0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22.00	HOME HEALTH AGENCY				22.00
23.00	AMBULANCE SERVICES				23.00
24.00	CMHC				24.00
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	STROGER PRO FEE CHARGES	0	6,032,479	6,032,479	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	420,158,232	588,264,225	1,008,422,457	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		688,458,718		29.00
30.00		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)		688,458,718		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 140124

Period:
From 12/01/2011
To 11/30/2012

Worksheet G-3

Date/Time Prepared:
4/30/2013 10:17 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	1,008,422,457	1.00
2.00	Less contractual allowances and discounts on patients' accounts	503,719,228	2.00
3.00	Net patient revenues (line 1 minus line 2)	504,703,229	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	688,458,718	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-183,755,489	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	39,306	7.00
8.00	Revenues from telephone and telegraph service	0	8.00
9.00	Revenue from television and radio service	0	9.00
10.00	Purchase discounts	0	10.00
11.00	Rebates and refunds of expenses	0	11.00
12.00	Parking lot receipts	2,938,046	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	364,443	16.00
17.00	Revenue from sale of drugs to other than patients	112	17.00
18.00	Revenue from sale of medical records and abstracts	89,848	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	224,927,764	23.00
24.00	OTHER	0	24.00
24.01	MISCELLANEOUS INCOME	2,918,188	24.01
25.00	Total other income (sum of lines 6-24)	231,277,707	25.00
26.00	Total (line 5 plus line 25)	47,522,218	26.00
27.00	ROUNDING	2	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	2	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	47,522,216	29.00

ANALYSIS OF RENAL DIALYSIS DEPARTMENT COSTS

Provider CCN: 140124

Period:

Worksheet I-1

Component CCN: 142313

From 12/01/2011
To 11/30/2012

Date/Time Prepared:
4/30/2013 10:17 am

Renal Dialysis

		Total Costs	Basis	Statistics	FTEs per 2080 Hours	
		1.00	2.00	3.00	4.00	
1.00	Registered Nurses	892,388	Hours of Service	19,120.00	9.19	1.00
2.00	Licensed Practical Nurses	187,522	Hours of Service	6,987.00	3.36	2.00
3.00	Nurses Aides	105,111	Hours of Service	5,935.00	2.85	3.00
4.00	Technicians	124,903	Hours of Service	3,582.00	1.72	4.00
5.00	Social Workers	0	Hours of Service	0.00	0.00	5.00
6.00	Dieticians	0	Hours of Service	0.00	0.00	6.00
7.00	Physicians	1,118,011	Accumulated Cost			7.00
8.00	Non-patient Care Salary	498,348	Accumulated Cost			8.00
9.00	Subtotal (sum of lines 1-8)	2,926,283				9.00
10.00	Employee Benefits	0	Salary			10.00
11.00	Capital Related Costs-Bldgs. & Fixtures	0	Square Feet			11.00
12.00	Capital Related Costs-Mov. Equip.	0	Percentage of Time			12.00
13.00	Machine Costs & Repairs	0	Percentage of Time			13.00
14.00	Supplies	263,266	Requisitions			14.00
15.00	Drugs	0	Requisitions			15.00
16.00	Other	0	Accumulated Cost			16.00
17.00	Subtotal (sum of lines 9-16)*	3,189,549				17.00
18.00	Capital Related Costs-Bldgs. & Fixtures	47,891	Square Feet			18.00
19.00	Capital Related Costs-Mov. Equip.	16,295	Percentage of Time			19.00
20.00	Employee Benefits	909,105	Salary			20.00
21.00	Administrative & General	1,139,423	Accumulated Cost			21.00
22.00	Maint./Repairs-Oper-Housekeeping	173,949	Square Feet			22.00
23.00	Medical Education Program Costs	0				23.00
24.00	Central Service & Supplies	66,380	Requisitions			24.00
25.00	Pharmacy	0	Requisitions			25.00
26.00	Other Allocated Costs	230,555	Accumulated Cost			26.00
27.00	Subtotal (sum of lines 17-26)*	5,773,147				27.00
28.00	Laboratory (see instructions)	0	Charges	0		28.00
29.00	Respiratory Therapy (see instructions)	0	Charges	0		29.00
30.00	Other (see instructions)	0	Charges	0		30.00
31.00	Total costs (sum of lines 27-30)	5,773,147				31.00

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

ALLOCATION OF RENAL DEPARTMENT COSTS TO TREATMENT MODALITIES

Provider CCN: 140124
Component CCN: 142313

Period:
From 12/01/2011
To 11/30/2012

Worksheet 1-2
Date/Time Prepared:
4/30/2013 10:17 am

		Capital Related Costs		Direct Patient Care Salary		Employee Benefits	
		Bui l di ng	Equi pment	RNs	Other		
		1.00	2.00	3.00	4.00		
1.00	Total Renal Department Costs	221,840	16,295	892,388	417,536	909,105	1.00
MAINTENANCE							
2.00	Hemodialysis	145,868	10,715	586,778	274,545	597,770	2.00
3.00	Intermittent Peritoneal	0	0	0	0	0	3.00
TRAINING							
4.00	Hemodialysis	0	0	0	0	0	4.00
5.00	Intermittent Peritoneal	0	0	0	0	0	5.00
6.00	CAPD	0	0	0	0	0	6.00
7.00	CCDP	0	0	0	0	0	7.00
HOME							
8.00	Hemodialysis	0	0	0	0	0	8.00
9.00	Intermittent Peritoneal	0	0	0	0	0	9.00
10.00	CAPD	0	0	0	0	0	10.00
11.00	CCDP	0	0	0	0	0	11.00
OTHER BILLABLE SERVICES							
12.00	Inpatient Dialysis	75,972	5,580	305,610	142,991	311,335	12.00
13.00	Method II Home Patient	0	0	0	0	0	13.00
14.00	EPO (include in Renal Department)						14.00
15.00	ARANESP (include in Renal Department)						15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Total (sum of lines 2-16)	221,840	16,295	892,388	417,536	909,105	17.00
18.00	Medical Educational Program Costs						18.00
19.00	Total Renal Costs (line 17 + line 18)						19.00

ALLOCATION OF RENAL DEPARTMENT COSTS TO TREATMENT MODALITIES		Provider CCN: 140124	Period: From 12/01/2011	Worksheet 1-2
		Component CCN: 142313	To 11/30/2012	Date/Time Prepared: 4/30/2013 10:17 am

		Drugs	Medical Supplies	Routine Ancillary Services	Subtotal (sum of cols. 1-8)	Overhead	
		6.00	7.00	8.00	9.00	10.00	
1.00	Total Renal Department Costs	0	329,646	0	2,786,810	2,986,337	1.00
MAINTENANCE							
2.00	Hemodialysis	0	216,754	0	1,832,430	1,963,626	2.00
3.00	Intermittent Peritoneal	0	0	0	0	0	3.00
TRAINING							
4.00	Hemodialysis	0	0	0	0	0	4.00
5.00	Intermittent Peritoneal	0	0	0	0	0	5.00
6.00	CAPD	0	0	0	0	0	6.00
7.00	CCDP	0	0	0	0	0	7.00
HOME							
8.00	Hemodialysis	0	0	0	0	0	8.00
9.00	Intermittent Peritoneal	0	0	0	0	0	9.00
10.00	CAPD	0	0	0	0	0	10.00
11.00	CCDP	0	0	0	0	0	11.00
OTHER BILLABLE SERVICES							
12.00	Inpatient Dialysis	0	112,892	0	954,380	1,022,711	12.00
13.00	Method II Home Patient	0	0	0	0	0	13.00
14.00	EPO (include in Renal Department)	0					14.00
15.00	ARANESP (include in Renal Department)	0					15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Total (sum of lines 2-16)	0	329,646	0	2,786,810	2,986,337	17.00
18.00	Medical Educational Program Costs						18.00
19.00	Total Renal Costs (line 17 + line 18)						19.00

ALLOCATION OF RENAL DEPARTMENT COSTS TO TREATMENT MODALITIES		Provider CCN: 140124	Period: From 12/01/2011 To 11/30/2012	Worksheet 1-2
		Component CCN: 142313	Date/Time Prepared: 4/30/2013 10:17 am	
		Renal Dialysis		

		Total (col. 9 + col. 10) 11.00		
1.00	Total Renal Department Costs	5,773,147		1.00
MAINTENANCE				
2.00	Hemodialysis	3,796,056		2.00
3.00	Intermittent Peritoneal	0		3.00
TRAINING				
4.00	Hemodialysis	0		4.00
5.00	Intermittent Peritoneal	0		5.00
6.00	CAPD	0		6.00
7.00	CCDP	0		7.00
HOME				
8.00	Hemodialysis	0		8.00
9.00	Intermittent Peritoneal	0		9.00
10.00	CAPD	0		10.00
11.00	CCDP	0		11.00
OTHER BILLABLE SERVICES				
12.00	Inpatient Dialysis	1,977,091		12.00
13.00	Method II Home Patient	0		13.00
14.00	EPO (include in Renal Department)			14.00
15.00	ARANESP (include in Renal Department)			15.00
16.00	Other	0		16.00
17.00	Total (sum of lines 2-16)	5,773,147		17.00
18.00	Medical Educational Program Costs	0		18.00
19.00	Total Renal Costs (line 17 + line 18)	5,773,147		19.00

DIRECT AND INDIRECT RENAL DIALYSIS COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140124
Component CCN: 142313

Period:
From 12/01/2011
To 11/30/2012

Worksheet 1-3
Date/Time Prepared:
4/30/2013 10:17 am

		Capital Related Costs		Direct Patient Care Salary			
		Building (Square Feet)	Equipment (% of Time)	RNs (Hours)	Other (Hours)		
		0	1.00	2.00	3.00	4.00	
1.00	Total Renal Department Costs		221,840	16,295	892,388	417,536	1.00
MAINTENANCE							
2.00	Hemodialysis		4,009	4,009.00	4,009.00	4,009.00	2.00
3.00	Intermittent Peritoneal		0	0.00	0.00	0.00	3.00
TRAINING							
4.00	Hemodialysis		0	0.00	0.00	0.00	4.00
5.00	Intermittent Peritoneal		0	0.00	0.00	0.00	5.00
6.00	CAPD		0	0.00	0.00	0.00	6.00
7.00	CCDP		0	0.00	0.00	0.00	7.00
HOME							
8.00	Hemodialysis		0	0.00	0.00	0.00	8.00
9.00	Intermittent Peritoneal		0	0.00	0.00	0.00	9.00
10.00	CAPD		0	0.00	0.00	0.00	10.00
11.00	CCDP		0	0.00	0.00	0.00	11.00
OTHER BILLABLE SERVICES							
12.00	Inpatient Dialysis Treatments	2,088	2,088	2,088.00	2,088.00	2,088.00	12.00
13.00	Method II Home Patient		0	0.00	0.00	0.00	13.00
14.00	EPO						14.00
15.00	ARANESP						15.00
16.00	Other		0	0.00	0.00	0.00	16.00
17.00	Total Statistical Basis		6,097	6,097.00	6,097.00	6,097.00	17.00
18.00	Unit Cost Multiplier (line 1 ÷ line 17)		36.385107	2.672626	146.365098	68.482204	18.00

DIRECT AND INDIRECT RENAL DIALYSIS COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140124
Component CCN: 142313

Period:
From 12/01/2011
To 11/30/2012

Worksheet 1-3
Date/Time Prepared:
4/30/2013 10:17 am

		Renal Dialysis				Subtotal	
		Employee Benefits (Salary)	Drugs (Requist.)	Medical Supplies (Requist.)	Routine Ancillary Services (Charges)		
		5.00	6.00	7.00	8.00	9.00	
1.00	Total Renal Department Costs	909,105	0	329,646	0	2,786,810	1.00
MAINTENANCE							
2.00	Hemodialysis	4,009	0	4,009	0		2.00
3.00	Intermittent Peritoneal	0	0	0	0		3.00
TRAINING							
4.00	Hemodialysis	0	0	0	0		4.00
5.00	Intermittent Peritoneal	0	0	0	0		5.00
6.00	CAPD	0	0	0	0		6.00
7.00	CCDP	0	0	0	0		7.00
HOME							
8.00	Hemodialysis	0	0	0	0		8.00
9.00	Intermittent Peritoneal	0	0	0	0		9.00
10.00	CAPD	0	0	0	0		10.00
11.00	CCDP	0	0	0	0		11.00
OTHER BILLABLE SERVICES							
12.00	Inpatient Dialysis Treatments	2,088	0	2,088	0		12.00
13.00	Method II Home Patient	0	0	0	0		13.00
14.00	EPO		0				14.00
15.00	ARANESP		0				15.00
16.00	Other	0	0	0	0		16.00
17.00	Total Statistical Basis	6,097	0	6,097	0		17.00
18.00	Unit Cost Multiplier (line 1 ÷ line 17)	149.106938	0.000000	54.066918	0.000000		18.00

DIRECT AND INDIRECT RENAL DIALYSIS COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140124

Period:

Worksheet 1-3

Component CCN: 142313

From 12/01/2011
To 11/30/2012

Date/Time Prepared:
4/30/2013 10:17 am

Renal Dialysis

		Overhead (Accum. Cost)	
		10.00	
1.00	Total Renal Department Costs	2,986,337	1.00
MAINTENANCE			
2.00	Hemodialysis		2.00
3.00	Intermittent Peritoneal		3.00
TRAINING			
4.00	Hemodialysis		4.00
5.00	Intermittent Peritoneal		5.00
6.00	CAPD		6.00
7.00	CCDP		7.00
HOME			
8.00	Hemodialysis		8.00
9.00	Intermittent Peritoneal		9.00
10.00	CAPD		10.00
11.00	CCDP		11.00
OTHER BILLABLE SERVICES			
12.00	Inpatient Dialysis Treatments		12.00
13.00	Method II Home Patient		13.00
14.00	EPO		14.00
15.00	ARANESP		15.00
16.00	Other		16.00
17.00	Total Statistical Basis	2,786,810	17.00
18.00	Unit Cost Multiplier (line 1 ÷ line 17)	1.071597	18.00

COMPUTATION OF AVERAGE COST PER TREATMENT FOR OUTPATIENT RENAL DIALYSIS

Provider CCN: 140124

Period: From 12/01/2011

Worksheet 1-4

Component CCN: 142313

To 11/30/2012

Date/Time Prepared: 4/30/2013 10:17 am

		Rate 0			Renal Dialysis		
		Number of Total Treatments	Total Cost (from Wkst. 1-2, col. 11)	Average Cost of Program Treatments (col. 2 ÷ col. 1)	Number of Program Treatments	Total Program Expenses (col. 4 x col. 3)	
		1.00	2.00	3.00	4.00	5.00	
1.00	Maintenance - Hemodialysis	4,009	3,796,056	946.88	1	947	1.00
2.00	Maintenance - Peritoneal Dialysis	0	0	0.00	0	0	2.00
3.00	Training - Hemodialysis	0	0	0.00	0	0	3.00
4.00	Training - Peritoneal Dialysis	0	0	0.00	0	0	4.00
5.00	Training - Continuous Ambulatory Peritoneal Dialysis	0	0	0.00	0	0	5.00
6.00	Training - Continuous Cycling Peritoneal Dialysis	0	0	0.00	0	0	6.00
7.00	Home Program - Hemodialysis	0	0	0.00	0	0	7.00
8.00	Home Program - Peritoneal Dialysis	0	0	0.00	0	0	8.00
		Patient Weeks			Patient Weeks		
		1.00	2.00	3.00	4.00	5.00	
9.00	Home Program - Continuous Ambulatory Peritoneal Dialysis	0	0	0.00	0	0	9.00
10.00	Home Program - Continuous Cycling Peritoneal Dialysis	0	0	0.00	0	0	10.00
11.00	Totals (sum of lines 1-8, columns 1 and 4) (sum of lines 1-10, columns 2, 5, and 6)	4,009	3,796,056		1	947	11.00

COMPUTATION OF AVERAGE COST PER TREATMENT FOR OUTPATIENT RENAL DIALYSIS

Provider CCN: 140124

Period:

Worksheet 1-4

Component CCN: 142313

From 12/01/2011
To 11/30/2012

Date/Time Prepared:
4/30/2013 10:17 am

Rate 0

Renal Dialysis

		Total Program Payment	Average Payment Rate (col. 6 ÷ col. 4)	
		6.00	7.00	
1.00	Maintenance - Hemodialysis	250	250.00	1.00
2.00	Maintenance - Peritoneal Dialysis	0	0.00	2.00
3.00	Training - Hemodialysis	0	0.00	3.00
4.00	Training - Peritoneal Dialysis	0	0.00	4.00
5.00	Training - Continuous Ambulatory Peritoneal Dialysis	0	0.00	5.00
6.00	Training - Continuous Cycling Peritoneal Dialysis	0	0.00	6.00
7.00	Home Program - Hemodialysis	0	0.00	7.00
8.00	Home Program - Peritoneal Dialysis	0	0.00	8.00
		6.00	7.00	
9.00	Home Program - Continuous Ambulatory Peritoneal Dialysis	0	0.00	9.00
10.00	Home Program - Continuous Cycling Peritoneal Dialysis	0	0.00	10.00
11.00	Totals (sum of lines 1-8, columns 1 and 4) (sum of lines 1-10, columns 2, 5, and 6)	250		11.00

CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B

Provider CCN: 140124

Period:
From 12/01/2011
To 11/30/2012

Worksheet I-5

Date/Time Prepared:
4/30/2013 10:17 am

		1.00	
1.00	Total expenses related to care of program beneficiaries (see instructions)	947	1.00
2.00	Total payment (from Worksheet I-4, column 6, line 11)	250	2.00
3.00	Deductibles billed to Medicare (Part B) patients	0	3.00
4.00	Coinsurance billed to Medicare (Part B) patients	0	4.00
5.00	Bad debts for deductibles and coinsurance, net of bad debt recoveries	0	5.00
6.00			6.00
7.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0	7.00
8.00	Net deductibles and coinsurance billed to Medicare (Part B) patients (sum of lines 3 and 4 less line 5)	0	8.00
9.00	Program payment (line 2 less line 3, times 80 percent)	200	9.00
10.00	Unrecovered from Medicare (Part B) patients (Line 1 minus the sum of lines 8 and 9. If negative, enter zero and do not complete line 11.)	747	10.00
11.00	Reimbursable bad debts (lesser of line 10 or line 5) (transfer to Worksheet E, Part B, line 33)	0	11.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 140124	Period: From 12/01/2011 To 11/30/2012	Worksheet L Parts I-III Date/Time Prepared: 4/30/2013 10:17 am
		Title XVIII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		1,455,102	1.00
2.00	Capital DRG outlier payments		325,962	2.00
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		298.38	3.00
4.00	Number of interns & residents (see instructions)		410.99	4.00
5.00	Indirect medical education percentage (see instructions)		47.51	5.00
6.00	Indirect medical education adjustment (line 1 times line 5)		691,319	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		13.22	7.00
8.00	Percentage of Medicaid patient days to total days reported on Worksheet S-3, Part I (see instructions)		46.83	8.00
9.00	Sum of lines 7 and 8		60.05	9.00
10.00	Allowable disproportionate share percentage (see instructions)		12.93	10.00
11.00	Disproportionate share adjustment (line 1 times line 10)		188,145	11.00
12.00	Total prospective capital payments (sum of lines 1-2, 6, and 11)		2,660,528	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