

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: 140300	Period: From 12/01/2011 To 11/30/2012	Worksheet S Parts I-III Date/Time Prepared: 4/29/2013 11:36 am
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PART I - COST REPORT STATUS

Provider use only	1. <input checked="" type="checkbox"/> Electronically filed cost report 2. <input type="checkbox"/> Manually submitted cost report 3. <input type="checkbox"/> If this is an amended report enter the number of times the provider resubmitted this cost report 4. <input type="checkbox"/> Medicare Utilization. Enter "F" for full or "L" for low.	Date: _____ Time: _____
Contractor use only	5. <input type="checkbox"/> Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	6. Date Received: _____ 7. Contractor No. _____ 8. <input type="checkbox"/> Initial Report for this Provider CCN 9. <input type="checkbox"/> Final Report for this Provider CCN 10. NPR Date: _____ 11. Contractor's Vendor Code: _____ 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 PROVIDENT HOSPITAL (140300) 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 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	-55,417	-563	-240,121	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	6.00
7.00 SKILLED NURSING FACILITY	0	0	0		0	7.00
8.00 NURSING FACILITY	0				0	8.00
9.00 HOME HEALTH AGENCY I	0	0	0		0	9.00
10.00 RURAL HEALTH CLINIC I	0				0	10.00
11.00 FEDERALLY QUALIFIED HEALTH CENTER I	0				0	11.00
12.00 CMHC I	0				0	12.00
200.00 Total	0	-55,417	-563	-240,121	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: 140300	Period: From 12/01/2011 To 11/30/2012	Worksheet S-2 Part I Date/Time Prepared: 4/29/2013 11:36 am
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1.00	2.00	3.00	4.00				1.00	2.00		
Hospital and Hospital Health Care Complex Address:										
Street: 500 EAST 51ST STREET		PO Box:		Zip Code: 60615-		County: COOK				
City: CHICAGO		State: IL								
	Component Name	CCN Number	CBSA Number	Provider Type	Date Certified	Payment System (P, T, O, or N)				
1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	9.00		
Hospital and Hospital -Based Component Identification:										
3.00	Hospital	PROVIDENT HOSPITAL	140300	16974	1	10/08/1993	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
17.10	Hospital -Based (CORF) I									17.10
18.00	Renal Dialysis									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)					13			21.00	
Inpatient PPS Information										
22.00	Does this facility qualify for and is it currently receiving payments for disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2) (Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no.					Y	N		22.00	
23.00	Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.					1	N		23.00	
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of-State Medicaid paid days	Out-of-State Medicaid eligible unpaid	Medicaid HMO days	Other Medicaid days			
		1.00	2.00	3.00	4.00	5.00	6.00			
24.00	If this provider is an IPPS hospital, enter the in-state Medicaid paid days in col. 1, in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid paid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.	816	1,523	0	0	14	0	0	24.00	
25.00	If this provider is an IRF, enter the in-state Medicaid paid days in col. 1, the in-state Medicaid eligible unpaid days in col. 2, out-of-state Medicaid days in col. 3, out-of-state Medicaid eligible unpaid days in col. 4, Medicaid HMO paid and eligible but unpaid days in col. 5, and other Medicaid days in col. 6.	0	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	

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		Beginning: 1.00	Ending: 2.00			
36.00	Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.					36.00
37.00	If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status in effect in the cost reporting period.	0				37.00
38.00	Enter applicable beginning and ending dates of MDH status. Subscript line 38 for number of periods in excess of one and enter subsequent dates.					38.00
		Y/N 1.00	Y/N 2.00			
39.00	Does the facility potentially qualify for the inpatient hospital adjustment for low volume hospitals as deemed by CMS according to the Federal Register? Enter in column 1 "Y" for yes or "N" for no. Additionally, does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)? Enter in column 2 "Y" for yes or "N" for no.					39.00
		V 1.00	XVIII 2.00	XIX 3.00		
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.		N			58.00
59.00	Are costs claimed on line 100 of Worksheet A? If yes, complete Worksheet D-2, Part I.		N			59.00
60.00	Are you claiming nursing school and/or allied health costs for a program that meets the provider-operated criteria under §413.85? Enter "Y" for yes or "N" for no. (see instructions)		N			60.00
		Y/N 1.00	IME 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

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	Program Name	Program Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
					5.00	
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))
			3.00
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))	
					5.00	
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		N	91.00	
92.00	Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.			N	92.00	
93.00	Does this facility operate an ICF/MR facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N		N	93.00	
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N		N	94.00	
95.00	If line 94 is "Y", enter the reduction percentage in the applicable column.		0.00		0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	N		N	96.00	
97.00	If line 96 is "Y", enter the reduction percentage in the applicable column.		0.00		0.00	97.00
Rural Providers						
105.00	Does this hospital qualify as a Critical Access Hospital (CAH)?	N				105.00
106.00	If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N				106.00
107.00	Column 1: If this facility qualifies as a CAH, is it eligible for cost reimbursement for I & R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination would not be on Worksheet B, Part I, column 25 and the program would be cost reimbursed. If yes complete Worksheet D-2, Part II. Column 2: If this facility is a CAH, do I&Rs in an approved medical education program train in the CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "N" for no in column 2. (see instructions)	N				107.00
108.00	Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N				108.00
		Physical	Occupational	Speech	Respiratory	
		1.00	2.00	3.00	4.00	
109.00	If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00
				1.00	2.00	3.00
Miscellaneous Cost Reporting Information						
115.00	Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter in column 3 either "93" percent for short term hospital or "98" percent for long term care (includes psychiatric, rehabilitation and long term hospital providers) based on the definition in CMS 15-1, §2208.1.	N			0	115.00
116.00	Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N				116.00
117.00	Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.	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:	285,899	600,000	119,031	118.01
			1.00	2.00	
118.02	Are malpractice premiums and paid losses reported in a cost center other than the Administrative and General? If yes, submit supporting schedule listing cost centers and amounts contained therein.		N		118.02
119.00	DO NOT USE THIS LINE				119.00
120.00	Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 1 "Y" for yes or "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in column 2 "Y" for yes or "N" for no.		N	N	120.00
121.00	Did this facility incur and report costs for implantable devices charged to patients? Enter "Y" for yes or "N" for no.		N		121.00
Transplant Center Information					
125.00	Does this facility operate a transplant center? Enter "Y" for yes and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.		N		125.00
126.00	If this is a Medicare certified kidney transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				126.00
127.00	If this is a Medicare certified heart transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				127.00
128.00	If this is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				128.00
129.00	If this is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				129.00
130.00	If this is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				130.00
131.00	If this is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				131.00
132.00	If this is a Medicare certified islet transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				132.00
133.00	If this is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2.				133.00
134.00	If this is an organ procurement organization (OPO), enter the OPO number in column 1 and termination date, if applicable, in column 2.				134.00
All Providers					
140.00	Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)		Y		140.00
		1.00	2.00	3.00	
If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.					
141.00	Name:	Contractor's Name:		Contractor's Number:	
142.00	Street:	PO Box:			
143.00	City:	State:		Zip Code:	
				1.00	
144.00	Are provider based physicians' costs included in Worksheet A?			Y	144.00
145.00	If costs for renal services are claimed on Worksheet A, line 74, are they costs for inpatient services only? Enter "Y" for yes or "N" for no.			Y	145.00
			1.00	2.00	
146.00	Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, section 4020) If yes, enter the approval date (mm/dd/yyyy) in column 2.		N		146.00
147.00	Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.		N		147.00
148.00	Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.		N		148.00
149.00	Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.		N		149.00
		Part A	Part B	Title V	Title XIX
		1.00	2.00	3.00	4.00
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)					
155.00	Hospital	N	N	N	N
156.00	Subprovider - IPF	N	N	N	N
157.00	Subprovider - IRF	N	N	N	N
158.00	SUBPROVIDER				
159.00	SNF	N	N	N	N
160.00	HOME HEALTH AGENCY	N	N	N	N
161.00	CMHC		N	N	N
161.10	CORF		N	N	N

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							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: 140300	Period: From 12/01/2011 To 11/30/2012	Worksheet S-2 Part II Date/Time Prepared: 4/29/2013 11:36 am	
			Y/N	Date	
			1.00	2.00	
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format.					
COMPLETED BY ALL HOSPITALS					
Provider Organization and Operation					
1.00	Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions)	N			1.00
			Y/N	Date	V/I
			1.00	2.00	3.00
2.00	Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary.	N			2.00
3.00	Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions)	Y			3.00
			Y/N	Type	Date
			1.00	2.00	3.00
Financial Data and Reports					
4.00	Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions.	N			4.00
5.00	Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation.	N			5.00
			Y/N	Legal Oper.	
			1.00	2.00	
Approved Educational Activities					
6.00	Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program?	N			6.00
7.00	Are costs claimed for Allied Health Programs? If "Y" see instructions.	N			7.00
8.00	Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	N			8.00
9.00	Are costs claimed for Intern-Resident programs claimed on the current cost report? If yes, see instructions.	Y			9.00
10.00	Was an Intern-Resident program been initiated or renewed in the current cost reporting period? If yes, see instructions.	N			10.00
11.00	Are GME cost directly assigned to cost centers other than I & R in an Approved Teaching Program on Worksheet A? If yes, see instructions.	N			11.00
				Y/N	
				1.00	
Bad Debts					
12.00	Is the provider seeking reimbursement for bad debts? If yes, see instructions.			Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.			N	13.00
14.00	If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.			N	14.00
Bed Complement					
15.00	Did total beds available change from the prior cost reporting period? If yes, see instructions.			N	15.00
		Part A		Part B	
Description		Y/N	Date	Y/N	
0		1.00	2.00	3.00	
PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions)	N		N	16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	N		N	17.00
18.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N	18.00
19.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N	19.00
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	N		N	20.00

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 140300	Period: From 12/01/2011 To 11/30/2012	Worksheet S-2 Part II Date/Time Prepared: 4/29/2013 11:36 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				22.00
23.00	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.				23.00
24.00	Were new leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see instructions				24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.				25.00
26.00	Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions.				26.00
27.00	Has the provider's capitalization policy changed during the cost reporting period? If yes, submit copy.				27.00
Interest Expense					
28.00	Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions.				28.00
29.00	Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) treated as a funded depreciation account? If yes, see instructions				29.00
30.00	Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see instructions.				30.00
31.00	Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.				31.00
Purchased Services					
32.00	Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions.				32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no, see instructions.				33.00
Provider-Based Physicians					
34.00	Are services furnished at the provider facility under an arrangement with provider-based physicians? If yes, see instructions.				34.00
35.00	If line 34 is yes, were there new agreements or amended existing agreements with the provider-based physicians during the cost reporting period? If yes, see instructions.				35.00
					Y/N
					Date
					1.00
					2.00
Home Office Costs					
36.00	Were home office costs claimed on the cost report?				36.00
37.00	If line 36 is yes, has a home office cost statement been prepared by the home office? If yes, see instructions.				37.00
38.00	If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office.				38.00
39.00	If line 36 is yes, did the provider render services to other chain components? If yes, see instructions.				39.00
40.00	If line 36 is yes, did the provider render services to the home office? If yes, see instructions.				40.00
					1.00
					2.00
Cost Report Preparer Contact Information					
41.00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	MI CHAEL		SUMRALL	41.00
42.00	Enter the employer/company name of the cost report preparer.	COOK COUNTY HEALTH & HOSPITALS SYSTE			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	312-864-4779		MSUMRALL@COOKCOUNTYHHS.ORG	43.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 140300

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

Worksheet S-3
Part I
Date/Time Prepared:
4/29/2013 11:36 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	94	34,404	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)		94	34,404	0.00	0	7.00
8.00 INTENSIVE CARE UNIT	31.00	15	5,490	0.00	0	8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY	43.00				0	13.00
14.00 Total (see instructions)		109	39,894	0.00	0	14.00
15.00 CAH visits					0	15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	41.00	0	0		0	17.00
18.00 SUBPROVIDER	42.00	0	0		0	18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	99.10				0	25.10
26.00 RURAL HEALTH CLINIC	88.00				0	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.25
27.00 Total (sum of lines 14-26)		109				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: 140300

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

Worksheet S-3
Part I
Date/Time Prepared:
4/29/2013 11:36 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)	896	2,339	6,194			1.00
2.00 HMO	70	14				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)	896	2,339	6,194			7.00
8.00 INTENSIVE CARE UNIT	0	0	0			8.00
9.00 CORONARY CARE UNIT						9.00
10.00 BURN INTENSIVE CARE UNIT						10.00
11.00 SURGICAL INTENSIVE CARE UNIT						11.00
12.00 OTHER SPECIAL CARE (SPECIFY)						12.00
13.00 NURSERY		0	0			13.00
14.00 Total (see instructions)	896	2,339	6,194	8.77	388.00	14.00
15.00 CAH visits	0	0	0			15.00
16.00 SUBPROVIDER - IPF						16.00
17.00 SUBPROVIDER - IRF	0	0	0	0.00	0.00	17.00
18.00 SUBPROVIDER	0	0	0	0.00	0.00	18.00
19.00 SKILLED NURSING FACILITY						19.00
20.00 NURSING FACILITY						20.00
21.00 OTHER LONG TERM CARE						21.00
22.00 HOME HEALTH AGENCY						22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)						23.00
24.00 HOSPICE						24.00
25.00 CMHC - CMHC						25.00
25.10 CMHC - CORF	0	0	0	0.00	0.00	25.10
26.00 RURAL HEALTH CLINIC	0	0	0	0.00	0.00	26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
27.00 Total (sum of lines 14-26)				8.77	388.00	27.00
28.00 Observation Bed Days		0	275			28.00
29.00 Ambulance Trips	0					29.00
30.00 Employee discount days (see instruction)			0			30.00
31.00 Employee discount days - IRF			0			31.00
32.00 Labor & delivery days (see instructions)		0	0			32.00
33.00 LTCH non-covered days	0					33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 140300

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

Worksheet S-3
Part I
Date/Time Prepared:
4/29/2013 11:36 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	228	525	1,657	1.00
2.00 HMO				17			2.00
3.00 HMO IPF Subprovider							3.00
4.00 HMO IRF Subprovider							4.00
5.00 Hospital Adults & Peds. Swing Bed SNF							5.00
6.00 Hospital Adults & Peds. Swing Bed NF							6.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions)							7.00
8.00 INTENSIVE CARE UNIT							8.00
9.00 CORONARY CARE UNIT							9.00
10.00 BURN INTENSIVE CARE UNIT							10.00
11.00 SURGICAL INTENSIVE CARE UNIT							11.00
12.00 OTHER SPECIAL CARE (SPECIFY)							12.00
13.00 NURSERY							13.00
14.00 Total (see instructions)	0.00	0	228	525	1,657		14.00
15.00 CAH visits							15.00
16.00 SUBPROVIDER - IPF							16.00
17.00 SUBPROVIDER - IRF	0.00	0	0	0	0	0	17.00
18.00 SUBPROVIDER	0.00	0	0	0	0	0	18.00
19.00 SKILLED NURSING FACILITY							19.00
20.00 NURSING FACILITY							20.00
21.00 OTHER LONG TERM CARE							21.00
22.00 HOME HEALTH AGENCY							22.00
23.00 AMBULATORY SURGICAL CENTER (D.P.)							23.00
24.00 HOSPICE							24.00
25.00 CMHC - CMHC							25.00
25.10 CMHC - CORF	0.00						25.10
26.00 RURAL HEALTH CLINIC	0.00						26.00
26.25 FEDERALLY QUALIFIED HEALTH CENTER	0.00						26.25
27.00 Total (sum of lines 14-26)	0.00						27.00
28.00 Observation Bed Days							28.00
29.00 Ambulance Trips							29.00
30.00 Employee discount days (see instruction)							30.00
31.00 Employee discount days - IRF							31.00
32.00 Labor & delivery days (see instructions)							32.00
33.00 LTCH non-covered days							33.00

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140300

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

Worksheet S-3
Part II
Date/Time Prepared:
4/29/2013 11:36 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	34,512,108	0	34,512,108	805,401.71	42.85
2.00	Non-physician anesthetist Part A		0	0	0	0.00	0.00
3.00	Non-physician anesthetist Part B		0	0	0	0.00	0.00
4.00	Physician-Part A - Administrative		3,076,854	0	3,076,854	21,993.60	139.90
4.01	Physicians - Part A - Teaching		8,254	0	8,254	59.00	139.90
5.00	Physician-Part B		9,167,781	0	9,167,781	82,593.82	111.00
6.00	Non-physician-Part B		0	0	0	0.00	0.00
7.00	Interns & residents (in an approved program)	21.00	0	440,920	440,920	8,764.20	50.31
7.01	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00
8.00	Home office personnel		0	0	0	0.00	0.00
9.00	SNF	44.00	0	0	0	0.00	0.00
10.00	Excluded area salaries (see instructions)		0	0	0	0.00	0.00
OTHER WAGES & RELATED COSTS							
11.00	Contract labor (see instructions)		623,034	0	623,034	9,971.72	62.48
12.00	Contract management and administrative services		3,455,317	0	3,455,317	74,851.60	46.16
13.00	Contract labor: Physician-Part A - Administrative		0	0	0	0.00	0.00
14.00	Home office salaries & wage-related costs		9,978,134	0	9,978,134	204,917.16	48.69
15.00	Home office: Physician Part A - Administrative		0	0	0	0.00	0.00
16.00	Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0.00
WAGE-RELATED COSTS							
17.00	Wage-related costs (core) Wkst S-3, Part IV line 24		6,868,919	0	6,868,919		
18.00	Wage-related costs (other) Wkst S-3, Part IV line 25		0	0	0		
19.00	Excluded areas		2,672,571	0	2,672,571		
20.00	Non-physician anesthetist Part A		0	0	0		
21.00	Non-physician anesthetist Part B		0	0	0		
22.00	Physician Part A - Administrative		0	0	0		
22.01	Physician Part A - Teaching		0	0	0		
23.00	Physician Part B		0	0	0		
24.00	Wage-related costs (RHC/FOHC)		0	0	0		
25.00	Interns & residents (in an approved program)		0	0	0		
OVERHEAD COSTS - DIRECT SALARIES							
26.00	Employee Benefits	4.00	0	0	0	0.00	0.00
27.00	Administrative & General	5.00	3,664,009	0	3,664,009	101,749.36	36.01
28.00	Administrative & General under contract (see inst.)		2,792,348	0	2,792,348	54,295.50	51.43
29.00	Maintenance & Repairs	6.00	1,075,886	0	1,075,886	26,655.20	40.36
30.00	Operation of Plant	7.00	826,591	0	826,591	16,643.10	49.67
31.00	Laundry & Linen Service	8.00	0	0	0	0.00	0.00
32.00	Housekeeping	9.00	1,371,035	0	1,371,035	64,381.18	21.30
33.00	Housekeeping under contract (see instructions)		0	0	0	0.00	0.00
34.00	Dietary	10.00	0	0	0	0.00	0.00
35.00	Dietary under contract (see instructions)		0	0	0	0.00	0.00
36.00	Cafeteria	11.00	0	0	0	0.00	0.00
37.00	Maintenance of Personnel	12.00	0	0	0	0.00	0.00
38.00	Nursing Administration	13.00	895,711	0	895,711	24,189.42	37.03
39.00	Central Services and Supply	14.00	0	0	0	0.00	0.00
40.00	Pharmacy	15.00	0	0	0	0.00	0.00
41.00	Medical Records & Medical Records Library	16.00	701,930	0	701,930	27,927.44	25.13

HOSPITAL WAGE INDEX INFORMATION		Worksheet A		Amount		Reclassification of Salaries		Adjusted Salaries		Paid Hours		Average Hourly Wage	
		Line Number	Reported	(from Worksheet A-6)	(col. 2 ± col. 3)							(col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00		6.00					
42.00	Social Service	17.00	435,763	0	435,763	14,667.00		29.71		42.00			
43.00	Other General Service	18.00	0	0	0	0.00		0.00		43.00			

HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 140300

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

Worksheet S-3
Part III
Date/Time Prepared:
4/29/2013 11:36 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)	28,128,421	-440,920	27,687,501	768,280.19	36.04	1.00
2.00	Excluded area salaries (see instructions)	0	0	0	0.00	0.00	2.00
3.00	Subtotal salaries (line 1 minus line 2)	28,128,421	-440,920	27,687,501	768,280.19	36.04	3.00
4.00	Subtotal other wages & related costs (see inst.)	14,056,485	0	14,056,485	289,740.48	48.51	4.00
5.00	Subtotal wage-related costs (see inst.)	6,868,919	0	6,868,919	0.00	24.81	5.00
6.00	Total (sum of lines 3 thru 5)	49,053,825	-440,920	48,612,905	1,058,020.67	45.95	6.00
7.00	Total overhead cost (see instructions)	11,763,273	0	11,763,273	330,508.20	35.59	7.00

HOSPITAL WAGE RELATED COSTS		Provider CCN: 140300	Period: From 12/01/2011 To 11/30/2012	Worksheet S-3 Part IV Date/Time Prepared: 4/29/2013 11:36 am
				Amount Reported
				1.00
PART IV - WAGE RELATED COSTS				
Part A - Core List				
RETIREMENT COST				
1.00	401K Employer Contributions			0 1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution			0 2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)			0 3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)			0 4.00
PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				
5.00	401K/TSA Plan Administration Fees			0 5.00
6.00	Legal/Accounting/Management Fees-Pension Plan		4,174,473	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)		4,270,224	8.00
9.00	Prescription Drug Plan		0	9.00
10.00	Dental, Hearing and Vision Plan		186,224	10.00
11.00	Life Insurance (If employee is owner or beneficiary)		69,344	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)		0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)		0	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)		0	14.00
15.00	'Workers' Compensation Insurance		0	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106. Non cumulative portion)		0	16.00
TAXES				
17.00	FICA-Employers Portion Only		429,804	17.00
18.00	Medicare Taxes - Employers Portion Only		0	18.00
19.00	Unemployment Insurance		104,206	19.00
20.00	State or Federal Unemployment Taxes		0	20.00
OTHER				
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on lines 1 through 4 above. (see instructions))		0	21.00
22.00	Day Care Cost and Allowances		0	22.00
23.00	Tuition Reimbursement		0	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)		9,234,275	24.00
Part B - Other than Core Related Cost				
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		0	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST

Provider CCN: 140300

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

Worksheet S-3
Part V
Date/Time Prepared:
4/29/2013 11:36 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	0	0	4.00
5.00	Subprovider - (Other)	0	0	5.00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7.00
8.00	Hospital-Based SNF			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	0	0	14.00
15.00	Hospital-Based Health Clinic FQHC	0	0	15.00
16.00	Hospital-Based-CMHC			16.00
16.10	Hospital-Based-CMHC 10	0	0	16.10
17.00	Renal Dialysis	0	0	17.00
18.00	Other	0	0	18.00

HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 140300	Period: From 12/01/2011 To 11/30/2012	Worksheet S-10 Date/Time Prepared: 4/29/2013 11:36 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)		0.810258	1.00	
Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid		6,198,382	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?		N	3.00	
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental payments from Medicaid?			4.00	
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medicaid		0	5.00	
6.00	Medicaid charges		6,312,464	6.00	
7.00	Medicaid cost (line 1 times line 6)		5,114,724	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		0	9.00	
10.00	Stand-alone SCHIP charges		0	10.00	
11.00	Stand-alone SCHIP cost (line 1 times line 10)		0	11.00	
12.00	Difference between net revenue and costs for stand-alone SCHIP (line 11 minus line 9; if < zero then enter zero)		0	12.00	
Other state or local government indigent care program (see instructions for each line)					
13.00	Net revenue from state or local indigent care program (Not included on lines 2, 5 or 9)		0	13.00	
14.00	Charges for patients covered under state or local indigent care program (Not included in lines 6 or 10)		0	14.00	
15.00	State or local indigent care program cost (line 1 times line 14)		0	15.00	
16.00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)		0	16.00	
Uncompensated care (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding charity care		0	17.00	
18.00	Government grants, appropriations or transfers for support of hospital operations		28,967,342	18.00	
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local indigent care programs (sum of lines 8, 12 and 16)		0	19.00	
			Uninsured patients	Insured patients	
			1.00	2.00	
			Total (col. 1 + col. 2)		
20.00	Total initial obligation of patients approved for charity care (at full charges excluding non-reimbursable cost centers) for the entire facility	23,527,006	0	23,527,006	20.00
21.00	Cost of initial obligation of patients approved for charity care (line 1 times line 20)	19,062,945	0	19,062,945	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)	19,062,945	0	19,062,945	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)		30,813,710	26.00	
27.00	Medicare bad debts for the entire hospital complex (see instructions)		31,232	27.00	
28.00	Non-Medicare and Non-Reimbursable bad debt expense (line 26 minus line 27)		30,782,478	28.00	
29.00	Cost of non-Medicare bad debt expense (line 1 times line 28)		24,941,749	29.00	
30.00	Cost of non-Medicare uncompensated care (line 23 column 3 plus line 29)		44,004,694	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)		44,004,694	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140300

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

Worksheet A
Date/Time Prepared:
4/29/2013 11:36 am

Cost Center Description		Salaries	Other	Total (col. 1 + col. 2)	Reclassified ons (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	NEW CAP REL COSTS-BLDG & FIXT		-311,138	-311,138	0	-311,138	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP		708,682	708,682	39,264	747,946	2.00
4.00	00400	EMPLOYEE BENEFITS	0	10,661,677	10,661,677	0	10,661,677	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	3,664,009	6,866,263	10,530,272	-1,590,385	8,939,887	5.00
6.00	00600	MAINTENANCE & REPAIRS	1,075,886	1,364,916	2,440,802	-66,745	2,374,057	6.00
7.00	00700	OPERATION OF PLANT	826,591	290,027	1,116,618	66,280	1,182,898	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	0	254,003	254,003	8.00
9.00	00900	HOUSEKEEPING	1,371,035	350,181	1,721,216	-99,451	1,621,765	9.00
10.00	01000	DIETARY	0	874,339	874,339	-873,000	1,339	10.00
11.00	01100	CAFETERIA	0	0	0	873,000	873,000	11.00
13.00	01300	NURSING ADMINISTRATION	895,711	326,599	1,222,310	-13,290	1,209,020	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	26,151	26,151	3,176,695	3,202,846	14.00
15.00	01500	PHARMACY	0	422,384	422,384	-413,664	8,720	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	701,930	116,612	818,542	0	818,542	16.00
17.00	01700	SOCIAL SERVICE	435,763	25,574	461,337	0	461,337	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	440,920	440,920	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	637,243	637,243	22.00
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	7,952,990	1,073,829	9,026,819	-609,533	8,417,286	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
41.00	04100	SUBPROVIDER - I&R	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS								
50.00	05000	OPERATING ROOM	2,803,202	504,351	3,307,553	-341,447	2,966,106	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	1,115,812	55,662	1,171,474	-53,745	1,117,729	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	2,225,150	1,132,942	3,358,092	-326,105	3,031,987	54.00
56.00	05600	RADIOISOTOPE	73,773	134	73,907	-134	73,773	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	1,722,339	703,439	2,425,778	-618,771	1,807,007	60.00
60.01	06001	BLOOD LABORATORY	236,596	92,827	329,423	-92,827	236,596	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	737,147	53,532	790,679	-53,176	737,503	65.00
66.00	06600	PHYSICAL THERAPY	155,982	315,771	471,753	-5,111	466,642	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	822,265	72,849	895,114	-36,608	858,506	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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	594,002	594,002	73.00
74.00	07400	RENAL DIALYSIS	0	482	482	-481	1	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	12,794	12,794	-9,084	3,710	90.00
91.00	09100	EMERGENCY	7,695,927	896,974	8,592,901	-877,850	7,715,051	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS								
99.10	09910	CORF	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS								
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	0	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	34,512,108	26,637,853	61,149,961	0	61,149,961	118.00
NONREIMBURSABLE COST CENTERS								
200.00		TOTAL (SUM OF LINES 118-199)	34,512,108	26,637,853	61,149,961	0	61,149,961	200.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 140300

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

Worksheet A
Date/Time Prepared:
4/29/2013 11:36 am

Cost Center Description			Adjustments (See A-8)	Net Expenses For Allocation	
			6.00	7.00	
GENERAL SERVICE COST CENTERS					
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT	658,946	347,808	1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP	378,028	1,125,974	2.00
4.00	00400	EMPLOYEE BENEFITS	1,035,612	11,697,289	4.00
5.00	00500	ADMINISTRATIVE & GENERAL	7,286,557	16,226,444	5.00
6.00	00600	MAINTENANCE & REPAIRS	0	2,374,057	6.00
7.00	00700	OPERATION OF PLANT	10,889	1,193,787	7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	254,003	8.00
9.00	00900	HOUSEKEEPING	0	1,621,765	9.00
10.00	01000	DIETARY	0	1,339	10.00
11.00	01100	CAFETERIA	0	873,000	11.00
13.00	01300	NURSING ADMINISTRATION	-16,123	1,192,897	13.00
14.00	01400	CENTRAL SERVICES & SUPPLY	0	3,202,846	14.00
15.00	01500	PHARMACY	-252,475	-243,755	15.00
16.00	01600	MEDICAL RECORDS & LIBRARY	0	818,542	16.00
17.00	01700	SOCIAL SERVICE	0	461,337	17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	440,920	21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	637,243	22.00
INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000	ADULTS & PEDIATRICS	-2,958,443	5,458,843	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	31.00
41.00	04100	SUBPROVIDER - I RF	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	42.00
43.00	04300	NURSERY	0	0	43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000	OPERATING ROOM	-1,307,441	1,658,665	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	-1,139,144	-21,415	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	-27,077	3,004,910	54.00
56.00	05600	RADIOISOTOPE	0	73,773	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	-498,202	1,308,805	60.00
60.01	06001	BLOOD LABORATORY	0	236,596	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	-15,379	722,124	65.00
66.00	06600	PHYSICAL THERAPY	0	466,642	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	-311,033	547,473	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	4,434,956	5,028,958	73.00
74.00	07400	RENAL DIALYSIS	0	1	74.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	2,572,312	2,576,022	90.00
91.00	09100	EMERGENCY	-3,835,314	3,879,737	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)			92.00
OTHER REIMBURSABLE COST CENTERS					
99.10	09910	CORF	0	0	99.10
SPECIAL PURPOSE COST CENTERS					
109.00	10900	PANCREAS ACQUISITION	0	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	110.00
111.00	11100	ISLET ACQUISITION	0	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	6,016,669	67,166,630	118.00
NONREIMBURSABLE COST CENTERS					
200.00		TOTAL (SUM OF LINES 118-199)	6,016,669	67,166,630	200.00

Provider CCN: 140300

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

Worksheet A-6

Date/Time Prepared:
4/29/2013 11:36 am

		Increases				
Cost Center		Line #	Salary	Other		
2.00	3.00	4.00	5.00			
A - DEFAULT						
1.00	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	39,264	1.00	
2.00	I&R SERVICES-OTHER PRGM COSTS APPRVD	22.00	0	637,243	2.00	
3.00	I&R SERVICES-SALARY & FRINGES APPRVD	21.00	440,920	0	3.00	
4.00	LAUNDRY & LINEN SERVICE	8.00	0	254,003	4.00	
5.00	DRUGS CHARGED TO PATIENTS	73.00	0	594,002	5.00	
6.00		0.00	0	0	6.00	
7.00		0.00	0	0	7.00	
8.00		0.00	0	0	8.00	
9.00		0.00	0	0	9.00	
10.00		0.00	0	0	10.00	
11.00		0.00	0	0	11.00	
12.00		0.00	0	0	12.00	
13.00		0.00	0	0	13.00	
14.00		0.00	0	0	14.00	
15.00		0.00	0	0	15.00	
16.00		0.00	0	0	16.00	
17.00		0.00	0	0	17.00	
18.00		0.00	0	0	18.00	
19.00		0.00	0	0	19.00	
20.00	CENTRAL SERVICES & SUPPLY	14.00	0	3,202,743	20.00	
21.00		0.00	0	0	21.00	
22.00		0.00	0	0	22.00	
23.00		0.00	0	0	23.00	
24.00		0.00	0	0	24.00	
25.00		0.00	0	0	25.00	
26.00		0.00	0	0	26.00	
27.00		0.00	0	0	27.00	
28.00		0.00	0	0	28.00	
29.00		0.00	0	0	29.00	
30.00		0.00	0	0	30.00	
31.00		0.00	0	0	31.00	
32.00		0.00	0	0	32.00	
33.00		0.00	0	0	33.00	
34.00		0.00	0	0	34.00	
35.00		0.00	0	0	35.00	
36.00		0.00	0	0	36.00	
37.00		0.00	0	0	37.00	
38.00		0.00	0	0	38.00	
39.00	CAFETERIA	11.00	0	873,000	39.00	
40.00	OPERATION OF PLANT	7.00	0	33,140	40.00	
	TOTALS		440,920	5,633,395		
C - LAWN MAINTENANCE						
1.00	OPERATION OF PLANT	7.00	0	33,140	1.00	
	TOTALS		0	33,140		
500.00	Grand Total: Increases		440,920	5,666,535	500.00	

RECLASSIFICATIONS

Provider CCN: 140300

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

Worksheet A-6

Date/Time Prepared:
4/29/2013 11:36 am

Decreases						
Cost Center	Line #	Salary	Other	Wkst. A-7 Ref.		
6.00	7.00	8.00	9.00	10.00		
A - DEFAULT						
1.00	ADMINISTRATIVE & GENERAL	5.00	0	39,264	10	1.00
2.00	EMERGENCY	91.00	0	637,243	0	2.00
3.00	ADULTS & PEDIATRICS	30.00	440,920	0	0	3.00
4.00	ADMINISTRATIVE & GENERAL	5.00	0	254,003	0	4.00
5.00	ADMINISTRATIVE & GENERAL	5.00	0	120,712	0	5.00
6.00	NURSING ADMINISTRATION	13.00	0	48	0	6.00
7.00	CENTRAL SERVICES & SUPPLY	14.00	0	21,530	0	7.00
8.00	PHARMACY	15.00	0	300,659	0	8.00
9.00	ADULTS & PEDIATRICS	30.00	0	16,977	0	9.00
10.00	OPERATING ROOM	50.00	0	27,580	0	10.00
11.00	ANESTHESIOLOGY	53.00	0	24,673	0	11.00
12.00	RADIOLOGY-DIAGNOSTIC	54.00	0	1,372	0	12.00
13.00	LABORATORY	60.00	0	11,818	0	13.00
14.00	RESPIRATORY THERAPY	65.00	0	198	0	14.00
15.00	PHYSICAL THERAPY	66.00	0	85	0	15.00
16.00	ELECTROCARDIOLOGY	69.00	0	34,128	0	16.00
17.00	RENAL DIALYSIS	74.00	0	247	0	17.00
18.00	CLINIC	90.00	0	1,344	0	18.00
19.00	EMERGENCY	91.00	0	32,631	0	19.00
20.00	ADMINISTRATIVE & GENERAL	5.00	0	1,176,406	0	20.00
21.00	MAINTENANCE & REPAIRS	6.00	0	465	0	21.00
22.00	HOUSEKEEPING	9.00	0	99,451	0	22.00
23.00	NURSING ADMINISTRATION	13.00	0	13,242	0	23.00
24.00	PHARMACY	15.00	0	113,005	0	24.00
25.00	ADULTS & PEDIATRICS	30.00	0	151,636	0	25.00
26.00	CENTRAL SERVICES & SUPPLY	14.00	0	4,518	0	26.00
27.00	OPERATING ROOM	50.00	0	313,867	0	27.00
28.00	RADIOISOTOPE	56.00	0	134	0	28.00
29.00	ANESTHESIOLOGY	53.00	0	29,072	0	29.00
30.00	RADIOLOGY-DIAGNOSTIC	54.00	0	324,733	0	30.00
31.00	LABORATORY	60.00	0	606,953	0	31.00
32.00	BLOOD LABORATORY	60.01	0	92,827	0	32.00
33.00	RESPIRATORY THERAPY	65.00	0	52,978	0	33.00
34.00	PHYSICAL THERAPY	66.00	0	5,026	0	34.00
35.00	ELECTROCARDIOLOGY	69.00	0	2,480	0	35.00
36.00	RENAL DIALYSIS	74.00	0	234	0	36.00
37.00	CLINIC	90.00	0	7,740	0	37.00
38.00	EMERGENCY	91.00	0	207,976	0	38.00
39.00	DIETARY	10.00	0	873,000	0	39.00
40.00	MAINTENANCE & REPAIRS	6.00	0	33,140	0	40.00
TOTALS			440,920	5,633,395		
C - LAWN MAINTENANCE						
1.00	MAINTENANCE & REPAIRS	6.00	0	33,140	0	1.00
TOTALS			0	33,140		
500.00	Grand Total: Decreases		440,920	5,666,535		500.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140300

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
4/29/2013 11:36 am

		Beginning Balances	Acquisitions			Disposals and Retirements	
			Purchases	Donation	Total		
		1.00	2.00	3.00	4.00	5.00	
PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES							
1.00	Land	0	0	0	0	0	1.00
2.00	Land Improvements	0	0	0	0	0	2.00
3.00	Buildings and Fixtures	0	0	0	0	0	3.00
4.00	Building Improvements	47,138,330	433,701	0	433,701	0	4.00
5.00	Fixed Equipment	20,950	0	0	0	0	5.00
6.00	Movable Equipment	12,448,480	116,105	0	116,105	0	6.00
7.00	HIT designated Assets	0	137,218	0	137,218	0	7.00
8.00	Subtotal (sum of lines 1-7)	59,607,760	687,024	0	687,024	0	8.00
9.00	Reconciling Items	0	0	0	0	0	9.00
10.00	Total (line 8 minus line 9)	59,607,760	687,024	0	687,024	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	NEW CAP REL COSTS-BLDG & FIXT	-311,138	0	0	0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	708,682	0	0	0	0	2.00
3.00	Total (sum of lines 1-2)	397,544	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	NEW CAP REL COSTS-BLDG & FIXT	-311,138	0	-311,138	-0.782650	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	708,682	0	708,682	1.782650	0	2.00
3.00	Total (sum of lines 1-2)	397,544	0	397,544	1.000000	0	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140300

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
4/29/2013 11:36 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	0	0		2.00		
3.00	Buildings and Fixtures	0	0		3.00		
4.00	Building Improvements	47,572,031	0		4.00		
5.00	Fixed Equipment	20,950	0		5.00		
6.00	Movable Equipment	12,564,585	0		6.00		
7.00	HIT designated Assets	137,218	0		7.00		
8.00	Subtotal (sum of lines 1-7)	60,294,784	0		8.00		
9.00	Reconciling Items	0	0		9.00		
10.00	Total (line 8 minus line 9)	60,294,784	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	NEW CAP REL COSTS-BLDG & FIXT	0	-311,138		1.00		
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	708,682		2.00		
3.00	Total (sum of lines 1-2)	0	397,544		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	NEW CAP REL COSTS-BLDG & FIXT	0	0	0	-311,138	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	1,086,710	39,264	2.00
3.00	Total (sum of lines 1-2)	0	0	0	775,572	39,264	3.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 140300

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

Worksheet A-7
Parts I-III
Date/Time Prepared:
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Cost Center Description	SUMMARY OF CAPITAL					Total (2) (sum of cols. 9 through 14)	
	Interest	Insurance (see instructions)	Taxes (see instructions)	Other Capital-Related Costs (see instructions)			
	11.00	12.00	13.00	14.00	15.00		
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	NEW CAP REL COSTS-BLDG & FIXT	658,946	0	0	0	347,808	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0	1,125,974	2.00
3.00	Total (sum of lines 1-2)	658,946	0	0	0	1,473,782	3.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 140300

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

Worksheet A-8

Date/Time Prepared:
4/29/2013 11:36 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
1.00 Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)			NEW CAP REL COSTS-BLDG & FIXT	1.00 1.00
2.00 Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)			NEW CAP 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	-91,719	EMPLOYEE BENEFITS	4.00 9.00
10.00 Provider-based physician adjustment	A-8-2	-10,813,483		10.00
11.00 Sale of scrap, waste, etc. (chapter 23)		0		0.00 11.00
12.00 Related organization transactions (chapter 10)	A-8-1	13,033,740		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		0		0.00 16.00
17.00 Sale of drugs to other than patients		0		0.00 17.00
18.00 Sale of medical records and abstracts		0		0.00 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 - NEW CAP REL COSTS-BLDG & FIXT			NEW CAP REL COSTS-BLDG & FIXT	1.00 26.00
27.00 Depreciation - NEW CAP REL COSTS-MVBLE EQUIP	A	378,028	NEW CAP REL COSTS-MVBLE EQUIP	2.00 27.00
28.00 Non-physician Anesthetist			0*** Cost Center Deleted ***	19.00 28.00
29.00 Physicians' assistant				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		0		0.00 33.00
34.00 MISC INCOME	B	8,065	ADMINISTRATIVE & GENERAL	5.00 34.00
35.00 PHARMACY SERVICE CHARGE	A	-252,475	PHARMACY	15.00 35.00
36.00 SENGSTACK CLINIC	A	2,572,312	CLINIC	90.00 36.00
37.00 COUNTY COST	A	268,471	EMPLOYEE BENEFITS	4.00 37.00
38.00 COUNTY COST	A	234,566	ADMINISTRATIVE & GENERAL	5.00 38.00
39.00 PARKING FEES	B	-63,099	ADMINISTRATIVE & GENERAL	5.00 39.00
40.00 EXPENSES ACCRUALS/REVERSALS	A	-202,582	EMPLOYEE BENEFITS	4.00 40.00
41.00 HOSPITAL MALPRACTICE INSURANCE	A	285,899	ADMINISTRATIVE & GENERAL	5.00 41.00
42.00 BOND INTEREST	A	658,946	NEW CAP REL COSTS-BLDG & FIXT	1.00 42.00
43.00		0		0.00 43.00
44.00 OTHER ADJUSTMENTS (SPECIFY)		0		0.00 44.00
45.00 OTHER ADJUSTMENTS (SPECIFY)		0		0.00 45.00
50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		6,016,669		50.00

ADJUSTMENTS TO EXPENSES

Provider CCN: 140300

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

Worksheet A-8

Date/Time Prepared:
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Cost Center Description		Wkst. A-7 Ref.	
		5.00	
1.00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	0	1.00
2.00	Investment income - NEW 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 - NEW CAP REL COSTS-BLDG & FIXT	0	26.00
27.00	Depreciation - NEW 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		0	33.00
34.00	MI SC INCOME	0	34.00
35.00	PHARMACY SERVICE CHARGE	0	35.00
36.00	SENGSTACK CLINIC	0	36.00
37.00	COUNTY COST	0	37.00
38.00	COUNTY COST	0	38.00
39.00	PARKING FEES	0	39.00
40.00	EXPENSES ACCRUALS/REVERSALS	0	40.00
41.00	HOSPITAL MALPRACTICE INSURANCE	0	41.00
42.00	BOND INTEREST	11	42.00
43.00		0	43.00
44.00	OTHER ADJUSTMENTS (SPECIFY)	0	44.00
45.00	OTHER ADJUSTMENTS (SPECIFY)	0	45.00
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: 140300

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

Worksheet A-8-1

Date/Time Prepared:
4/29/2013 11:36 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	5.00	ADMINISTRATIVE & GENERAL	BUREAU OF HEALTH ALLOCATED COST	1.00
2.00	73.00	DRUGS CHARGED TO PATIENTS	BUREAU OF HEALTH ALLOCATED COST	2.00
3.00	4.00	EMPLOYEE BENEFITS	BUREAU OF HEALTH ALLOCATED COST	3.00
4.00	7.00	OPERATION OF PLANT	COOK COUNTY ALLOCATED COST	4.00
4.10	0.00		COOK COUNTY ALLOCATED COST	4.10
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	COOK COUNTY	100.00	6.00
7.00			0.00	7.00
8.00			0.00	8.00
9.00			0.00	9.00
10.00			0.00	10.00
100.00	G. Other (financial or non-financial) specify:			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: 140300

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

Worksheet A-8-1

Date/Time Prepared: 4/29/2013 11:36 am

	Amount of Allowable Cost	Amount Included in Wks. A, column 5	Net Adjustments (col. 4 minus col. 5)*	Wkst. A-7 Ref.	
	4.00	5.00	6.00	7.00	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:					
1.00	7,526,453	0	7,526,453	0	1.00
2.00	4,434,956	0	4,434,956	0	2.00
3.00	1,061,442	0	1,061,442	0	3.00
4.00	10,889	0	10,889	0	4.00
4.10	0	0	0	0	4.10
5.00	TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.	13,033,740	0	13,033,740	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		COOK COUNTY	100.00	GOVERNMENT	6.00
7.00			0.00		7.00
8.00			0.00		8.00
9.00			0.00		9.00
10.00			0.00		10.00
100.00	G. Other (financial or non-financial) specify:				100.00

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

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 140300

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

Worksheet A-8-2

Date/Time Prepared:
4/29/2013 11:36 am

		Wkst. A Line #	Cost Center/Physician Identifier	Total Remuneration	Professional Component	
		1.00	2.00	3.00	4.00	
1.00		5.00	ADMINISTRATIVE & GENERAL	705,327	705,327	1.00
2.00		13.00	NURSING ADMINISTRATION	16,123	16,123	2.00
3.00		30.00	ADULTS & PEDIATRICS	2,791,119	1,938,567	3.00
4.00		30.00	ADULTS & PEDIATRICS	266,714	5,283	4.00
5.00		50.00	OPERATING ROOM	1,523,458	1,213,498	5.00
6.00		53.00	ANESTHESIOLOGY	1,714,514	875,021	6.00
7.00		54.00	RADIOLOGY-DIAGNOSTIC	17,077	17,077	7.00
8.00		60.00	LABORATORY	498,202	498,202	8.00
9.00		65.00	RESPIRATORY THERAPY	15,379	15,379	9.00
10.00		69.00	ELECTROCARDIOLOGY	491,925	230,587	10.00
11.00		91.00	EMERGENCY	4,204,796	3,652,716	11.00
12.00		30.00	ADULTS & PEDIATRICS	594,790	594,790	12.00
13.00		54.00	RADIOLOGY-DIAGNOSTIC	10,000	10,000	13.00
200.00				12,849,424	9,772,570	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 140300

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

Worksheet A-8-2

Date/Time Prepared:
4/29/2013 11:36 am

	Provider Component	RCE Amount	Physician/Provider Component Hours	Unadjusted RCE Limit	5 Percent of Unadjusted RCE Limit	
	5.00	6.00	7.00	8.00	9.00	
1.00	0	0	0	0	0	1.00
2.00	0	0	0	0	0	2.00
3.00	852,552	177,200	5,818	495,649	24,782	3.00
4.00	261,431	177,200	2,080	177,200	8,860	4.00
5.00	309,960	208,000	2,072	207,200	10,360	5.00
6.00	839,493	200,300	5,816	560,070	28,004	6.00
7.00	0	225,300	0	0	0	7.00
8.00	0	215,700	0	0	0	8.00
9.00	0	0	0	0	0	9.00
10.00	261,337	177,200	2,072	176,518	8,826	10.00
11.00	552,080	177,200	4,136	352,355	17,618	11.00
12.00	0	0	0	0	0	12.00
13.00	0	0	0	0	0	13.00
200.00	3,076,853		21,994	1,968,992	98,450	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 140300

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

Worksheet A-8-2

Date/Time Prepared:
4/29/2013 11:36 am

	Cost of Memberships & Continuing Education 12.00	Provider Component Share of col. 12 13.00	Physician Cost of Malpractice Insurance 14.00	Provider Component Share of col. 14 15.00	Adjusted RCE Limit 16.00	
1.00	0	0	25,188	0	0	1.00
2.00	0	0	576	0	0	2.00
3.00	0	0	69,228	21,146	516,795	3.00
4.00	0	0	189	185	177,385	4.00
5.00	0	0	43,335	8,817	216,017	5.00
6.00	0	0	31,248	15,300	575,370	6.00
7.00	0	0	610	0	0	7.00
8.00	0	0	17,791	0	0	8.00
9.00	0	0	549	0	0	9.00
10.00	0	0	8,234	4,374	180,892	10.00
11.00	0	0	130,441	17,127	369,482	11.00
12.00	0	0	21,240	0	0	12.00
13.00	0	0	357	0	0	13.00
200.00	0	0	348,986	66,949	2,035,941	200.00

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 140300

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

Worksheet A-8-2

Date/Time Prepared:
4/29/2013 11:36 am

	RCE	Adjustment	
	Disallowance		
	17.00	18.00	
1.00	0	705,327	1.00
2.00	0	16,123	2.00
3.00	335,757	2,274,324	3.00
4.00	84,046	89,329	4.00
5.00	93,943	1,307,441	5.00
6.00	264,123	1,139,144	6.00
7.00	0	17,077	7.00
8.00	0	498,202	8.00
9.00	0	15,379	9.00
10.00	80,445	311,033	10.00
11.00	182,598	3,835,314	11.00
12.00	0	594,790	12.00
13.00	0	10,000	13.00
200.00	1,040,912	10,813,483	200.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140300

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

Worksheet B
Part I
Date/Time Prepared:
4/29/2013 11:36 am

Cost Center Description	Net Expenses for Cost Allocation (from Wkst Allocation)	CAPITAL RELATED COSTS		EMPLOYEE BENEFITS	Subtotal	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
	0	1.00	2.00	4.00	4A	
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT	347,808	347,808			1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP	1,125,974		1,125,974		2.00
4.00 00400	EMPLOYEE BENEFITS	11,697,289	3,695	0	11,700,984	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	16,226,444	98,256	233,811	1,242,246	17,800,757
6.00 00600	MAINTENANCE & REPAIRS	2,374,057	1,218	26,387	364,768	2,766,430
7.00 00700	OPERATION OF PLANT	1,193,787	54,250	109,305	280,247	1,637,589
8.00 00800	LAUNDRY & LINEN SERVICE	254,003	0	0	0	254,003
9.00 00900	HOUSEKEEPING	1,621,765	1,054	12,108	464,836	2,099,763
10.00 01000	DIETARY	1,339	11,710	0	0	13,049
11.00 01100	CAFETERIA	873,000	5,257	0	0	878,257
13.00 01300	NURSING ADMINISTRATION	1,192,897	2,499	64,138	303,682	1,563,216
14.00 01400	CENTRAL SERVICES & SUPPLY	3,202,846	1,695	8,155	0	3,212,696
15.00 01500	PHARMACY	-243,755	2,267	3,436	0	-238,052
16.00 01600	MEDICAL RECORDS & LIBRARY	818,542	8,065	0	237,982	1,064,589
17.00 01700	SOCIAL SERVICE	461,337	1,141	0	147,741	610,219
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	440,920	0	0	0	440,920
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	637,243	0	0	0	637,243
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	5,458,843	26,009	175,479	2,696,380	8,356,711
31.00 03100	INTENSIVE CARE UNIT	0	0	0	0	0
41.00 04100	SUBPROVIDER - I&R	0	0	0	0	0
42.00 04200	SUBPROVIDER	0	0	0	0	0
43.00 04300	NURSERY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	1,658,665	21,820	116,772	950,398	2,747,655
51.00 05100	RECOVERY ROOM	0	0	0	0	0
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0
53.00 05300	ANESTHESIOLOGY	-21,415	6,204	0	378,305	363,094
54.00 05400	RADIOLOGY-DIAGNOSTIC	3,004,910	23,090	288,413	754,415	4,070,828
56.00 05600	RADIOISOTOPE	73,773	1,126	0	25,012	99,911
57.00 05700	CT SCAN	0	0	0	0	0
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00 06000	LABORATORY	1,308,805	18,477	13,222	583,942	1,924,446
60.01 06001	BLOOD LABORATORY	236,596	0	0	0	236,596
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	740	1,043	80,216	81,999
65.00 06500	RESPIRATORY THERAPY	722,124	4,416	26,341	249,922	1,002,803
66.00 06600	PHYSICAL THERAPY	466,642	941	6,902	52,884	527,369
67.00 06700	OCCUPATIONAL THERAPY	0	2,008	0	0	2,008
68.00 06800	SPEECH PATHOLOGY	0	603	0	0	603
69.00 06900	ELECTROCARDIOLOGY	547,473	1,668	34,822	278,781	862,744
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00 07300	DRUGS CHARGED TO PATIENTS	5,028,958	0	0	0	5,028,958
74.00 07400	RENAL DIALYSIS	1	0	0	0	1
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	0
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00 09000	CLINIC	2,576,022	28,606	3,615	0	2,608,243
91.00 09100	EMERGENCY	3,879,737	20,993	2,025	2,609,227	6,511,982
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0
OTHER REIMBURSABLE COST CENTERS						
99.10 09910	CORF	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS						
109.00 10900	PANCREAS ACQUISITION	0	0	0	0	0
110.00 11000	INTESTINAL ACQUISITION	0	0	0	0	0
111.00 11100	ISLET ACQUISITION	0	0	0	0	0
118.00	SUBTOTALS (SUM OF LINES 1-117)	67,166,630	347,808	1,125,974	11,700,984	67,166,630
NONREIMBURSABLE COST CENTERS						
200.00	Cross Foot Adjustments		0	0	0	0
201.00	Negative Cost Centers		0	0	0	0
202.00	TOTAL (sum lines 118-201)	67,166,630	347,808	1,125,974	11,700,984	67,166,630

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140300

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

Worksheet B
Part I
Date/Time Prepared:
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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	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	17,800,757				5.00
6.00	00600	MAINTENANCE & REPAIRS	992,756	3,759,186			6.00
7.00	00700	OPERATION OF PLANT	587,662	833,624	3,058,875		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	91,151	0	0	345,154	8.00
9.00	00900	HOUSEKEEPING	753,517	16,194	16,932	21,059	2,907,465
10.00	01000	DIETARY	4,683	179,931	188,131	0	0
11.00	01100	CAFETERIA	315,170	80,784	84,465	0	9,736
13.00	01300	NURSING ADMINISTRATION	560,973	38,404	40,154	0	464,066
14.00	01400	CENTRAL SERVICES & SUPPLY	1,152,902	26,041	27,228	0	23,382
15.00	01500	PHARMACY	0	34,832	36,420	379	22,883
16.00	01600	MEDICAL RECORDS & LIBRARY	382,036	123,931	129,578	0	9,736
17.00	01700	SOCIAL SERVICE	218,982	17,539	18,338	0	16,226
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	158,228	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	228,680	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	2,998,861	399,655	417,866	279,914	1,173,689
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0
41.00	04100	SUBPROVIDER - I RF	0	0	0	0	0
42.00	04200	SUBPROVIDER	0	0	0	0	0
43.00	04300	NURSERY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	986,018	335,297	350,575	42,185	9,652
51.00	05100	RECOVERY ROOM	0	0	0	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0
53.00	05300	ANESTHESIOLOGY	130,299	95,330	99,674	102	9,652
54.00	05400	RADIOLOGY-DIAGNOSTIC	1,460,849	354,802	370,970	481	117,826
56.00	05600	RADIOISOTOPE	35,854	17,308	18,096	0	6,490
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	690,603	283,923	296,860	553	28,791
60.01	06001	BLOOD LABORATORY	84,904	0	0	0	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	29,426	11,365	11,883	57	14,395
65.00	06500	RESPIRATORY THERAPY	359,864	67,857	70,950	248	2,413
66.00	06600	PHYSICAL THERAPY	189,251	14,459	15,118	15	9,736
67.00	06700	OCCUPATIONAL THERAPY	721	30,856	32,262	0	2,413
68.00	06800	SPEECH PATHOLOGY	216	9,268	9,691	15	2,413
69.00	06900	ELECTROCARDIOLOGY	309,603	25,636	26,805	88	2,413
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	1,804,682	0	0	0	0
74.00	07400	RENAL DIALYSIS	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00	09000	CLINIC	935,989	439,563	459,593	58	0
91.00	09100	EMERGENCY	2,336,877	322,587	337,286	0	981,553
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0
111.00	11100	ISLET ACQUISITION	0	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	17,800,757	3,759,186	3,058,875	345,154	2,907,465
NONREIMBURSABLE COST CENTERS							
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	17,800,757	3,759,186	3,058,875	345,154	2,907,465

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140300

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

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	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	385,794					10.00
11.00	01100	0	1,368,412				11.00
13.00	01300	0	51,932	2,718,745			13.00
14.00	01400	0	0	0	4,442,249		14.00
15.00	01500	0	0	0	265,128	121,590	15.00
16.00	01600	0	62,251	0	0	0	16.00
17.00	01700	0	19,474	38,158	0	0	17.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	318,916	679,613	1,093,562	352,741	10,268	30.00
31.00	03100	0	0	0	0	0	31.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	115,009	472,320	730,129	21,253	50.00
51.00	05100	0	0	0	0	0	51.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	0	0	0	67,628	1,969	53.00
54.00	05400	0	86,563	35,266	755,406	21,989	54.00
56.00	05600	0	2,649	0	312	9	56.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	0	85,767	0	1,411,917	41,098	60.00
60.01	06001	0	0	0	0	0	60.01
62.00	06200	0	11,467	0	215,938	6,286	62.00
65.00	06500	0	50,906	0	123,239	3,587	65.00
66.00	06600	0	5,496	0	11,692	340	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	0	11,605	0	5,769	168	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	0	0	0	0	0	73.00
74.00	07400	0	0	0	544	16	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	0	0	0	18,005	524	90.00
91.00	09100	66,878	185,680	1,079,439	483,801	14,083	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900	0	0	0	0	0	109.00
110.00	11000	0	0	0	0	0	110.00
111.00	11100	0	0	0	0	0	111.00
118.00		385,794	1,368,412	2,718,745	4,442,249	121,590	118.00
NONREIMBURSABLE COST CENTERS							
200.00							200.00
201.00		0	0	0	0	0	201.00
202.00		385,794	1,368,412	2,718,745	4,442,249	121,590	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140300

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

Worksheet B
Part I
Date/Time Prepared:
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Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS		Subtotal		
			SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS			
			16.00	17.00			21.00
GENERAL SERVICE COST CENTERS							
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00	
2.00 00200 NEW 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	
15.00 01500 PHARMACY						15.00	
16.00 01600 MEDICAL RECORDS & LIBRARY	1,772,121					16.00	
17.00 01700 SOCIAL SERVICE	144	939,080				17.00	
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	599,148			21.00	
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	865,923		22.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000 ADULTS & PEDIATRICS	93,595	434,222	273,071	394,657	17,277,341	30.00	
31.00 03100 INTENSIVE CARE UNIT	0	0	0	0	0	31.00	
41.00 04100 SUBPROVIDER - IRF	0	0	0	0	0	41.00	
42.00 04200 SUBPROVIDER	0	0	0	0	0	42.00	
43.00 04300 NURSERY	0	0	0	0	0	43.00	
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	8,763	0	26,747	38,656	5,884,259	50.00	
51.00 05100 RECOVERY ROOM	0	0	0	0	0	51.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00	
53.00 05300 ANESTHESIOLOGY	0	0	3,351	4,843	775,942	53.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	215	0	0	0	7,275,195	54.00	
56.00 05600 RADIOISOTOPE	0	0	0	0	180,629	56.00	
57.00 05700 CT SCAN	0	0	0	0	0	57.00	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00	
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	59.00	
60.00 06000 LABORATORY	646	0	0	0	4,764,604	60.00	
60.01 06001 BLOOD LABORATORY	0	0	0	0	321,500	60.01	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	382,816	62.00	
65.00 06500 RESPIRATORY THERAPY	0	0	0	0	1,681,867	65.00	
66.00 06600 PHYSICAL THERAPY	0	0	0	0	773,476	66.00	
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	0	68,260	67.00	
68.00 06800 SPEECH PATHOLOGY	0	0	0	0	22,206	68.00	
69.00 06900 ELECTROCARDIOLOGY	0	0	0	0	1,244,831	69.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	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	6,833,640	73.00	
74.00 07400 RENAL DIALYSIS	0	0	0	0	561	74.00	
OUTPATIENT SERVICE COST CENTERS							
88.00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00	
90.00 09000 CLINIC	1,004,473	504,858	40,394	58,380	6,070,080	90.00	
91.00 09100 EMERGENCY	664,285	0	255,585	369,387	13,609,423	91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00	
OTHER REIMBURSABLE COST CENTERS							
99.10 09910 CORF	0	0	0	0	0	99.10	
SPECIAL PURPOSE COST CENTERS							
109.00 10900 PANCREAS ACQUISITION	0	0	0	0	0	109.00	
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0	110.00	
111.00 11100 ISLET ACQUISITION	0	0	0	0	0	111.00	
118.00	SUBTOTALS (SUM OF LINES 1-117)	1,772,121	939,080	599,148	865,923	67,166,630	118.00
NONREIMBURSABLE COST CENTERS							
200.00	Cross Foot Adjustments			0	0	0	200.00
201.00	Negative Cost Centers	0	0	0	0	0	201.00
202.00	TOTAL (sum lines 118-201)	1,772,121	939,080	599,148	865,923	67,166,630	202.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 140300

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

Worksheet B
Part I
Date/Time Prepared:
4/29/2013 11:36 am

Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
GENERAL SERVICE COST CENTERS				
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT			1.00
2.00	00200 NEW 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
15.00	01500 PHARMACY			15.00
16.00	01600 MEDICAL RECORDS & LIBRARY			16.00
17.00	01700 SOCIAL SERVICE			17.00
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRVD			21.00
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD			22.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS	-667,728	16,609,613	30.00
31.00	03100 INTENSIVE CARE UNIT	0	0	31.00
41.00	04100 SUBPROVIDER - IRF	0	0	41.00
42.00	04200 SUBPROVIDER	0	0	42.00
43.00	04300 NURSERY	0	0	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	-65,403	5,818,856	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	-8,194	767,748	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	0	7,275,195	54.00
56.00	05600 RADIOISOTOPE	0	180,629	56.00
57.00	05700 CT SCAN	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000 LABORATORY	0	4,764,604	60.00
60.01	06001 BLOOD LABORATORY	0	321,500	60.01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	382,816	62.00
65.00	06500 RESPIRATORY THERAPY	0	1,681,867	65.00
66.00	06600 PHYSICAL THERAPY	0	773,476	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	68,260	67.00
68.00	06800 SPEECH PATHOLOGY	0	22,206	68.00
69.00	06900 ELECTROCARDIOLOGY	0	1,244,831	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	6,833,640	73.00
74.00	07400 RENAL DIALYSIS	0	561	74.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000 CLINIC	-98,774	5,971,306	90.00
91.00	09100 EMERGENCY	-624,972	12,984,451	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
OTHER REIMBURSABLE COST CENTERS				
99.10	09910 CORF	0	0	99.10
SPECIAL PURPOSE COST CENTERS				
109.00	10900 PANCREAS ACQUISITION	0	0	109.00
110.00	11000 INTESTINAL ACQUISITION	0	0	110.00
111.00	11100 ISLET ACQUISITION	0	0	111.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	-1,465,071	65,701,559	118.00
NONREIMBURSABLE COST CENTERS				
200.00	Cross Foot Adjustments	0	0	200.00
201.00	Negative Cost Centers	0	0	201.00
202.00	TOTAL (sum lines 118-201)	-1,465,071	65,701,559	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140300

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

Worksheet B
Part II
Date/Time Prepared:
4/29/2013 11:36 am

Cost Center Description	Directly Assigned New Capital Related Costs	CAPITAL RELATED COSTS		Subtotal	EMPLOYEE BENEFITS	
		NEW BLDG & FIXT	NEW MVBLE EQUIP			
		0	2.00			
GENERAL SERVICE COST CENTERS						
1.00 00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400	EMPLOYEE BENEFITS	0	3,695	3,695	3,695	4.00
5.00 00500	ADMINISTRATIVE & GENERAL	0	98,256	233,811	332,067	5.00
6.00 00600	MAINTENANCE & REPAIRS	0	1,218	26,387	27,605	6.00
7.00 00700	OPERATION OF PLANT	0	54,250	109,305	163,555	7.00
8.00 00800	LAUNDRY & LINEN SERVICE	0	0	0	0	8.00
9.00 00900	HOUSEKEEPING	0	1,054	12,108	13,162	9.00
10.00 01000	DIETARY	0	11,710	0	11,710	10.00
11.00 01100	CAFETERIA	0	5,257	0	5,257	11.00
13.00 01300	NURSING ADMINISTRATION	0	2,499	64,138	66,637	13.00
14.00 01400	CENTRAL SERVICES & SUPPLY	0	1,695	8,155	9,850	14.00
15.00 01500	PHARMACY	0	2,267	3,436	5,703	15.00
16.00 01600	MEDICAL RECORDS & LIBRARY	0	8,065	0	8,065	16.00
17.00 01700	SOCIAL SERVICE	0	1,141	0	1,141	17.00
21.00 02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	21.00
22.00 02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000	ADULTS & PEDIATRICS	0	26,009	175,479	201,488	30.00
31.00 03100	INTENSIVE CARE UNIT	0	0	0	0	31.00
41.00 04100	SUBPROVIDER - IRF	0	0	0	0	41.00
42.00 04200	SUBPROVIDER	0	0	0	0	42.00
43.00 04300	NURSERY	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS						
50.00 05000	OPERATING ROOM	0	21,820	116,772	138,592	50.00
51.00 05100	RECOVERY ROOM	0	0	0	0	51.00
52.00 05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00 05300	ANESTHESIOLOGY	0	6,204	0	6,204	53.00
54.00 05400	RADIOLOGY-DIAGNOSTIC	0	23,090	288,413	311,503	54.00
56.00 05600	RADIOISOTOPE	0	1,126	0	1,126	56.00
57.00 05700	CT SCAN	0	0	0	0	57.00
58.00 05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00 05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00 06000	LABORATORY	0	18,477	13,222	31,699	60.00
60.01 06001	BLOOD LABORATORY	0	0	0	0	60.01
62.00 06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	740	1,043	1,783	62.00
65.00 06500	RESPIRATORY THERAPY	0	4,416	26,341	30,757	65.00
66.00 06600	PHYSICAL THERAPY	0	941	6,902	7,843	66.00
67.00 06700	OCCUPATIONAL THERAPY	0	2,008	0	2,008	67.00
68.00 06800	SPEECH PATHOLOGY	0	603	0	603	68.00
69.00 06900	ELECTROCARDIOLOGY	0	1,668	34,822	36,490	69.00
71.00 07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00 07400	RENAL DIALYSIS	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00 08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00 09000	CLINIC	0	28,606	3,615	32,221	90.00
91.00 09100	EMERGENCY	0	20,993	2,025	23,018	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
99.10 09910	CORF	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS						
109.00 10900	PANCREAS ACQUISITION	0	0	0	0	109.00
110.00 11000	INTESTINAL ACQUISITION	0	0	0	0	110.00
111.00 11100	ISLET ACQUISITION	0	0	0	0	111.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	347,808	1,125,974	1,473,782	118.00
NONREIMBURSABLE COST CENTERS						
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)	0	347,808	1,125,974	1,473,782	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140300

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

Worksheet B
Part II
Date/Time Prepared:
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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	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00	00400	EMPLOYEE BENEFITS					4.00
5.00	00500	ADMINISTRATIVE & GENERAL	332,459				5.00
6.00	00600	MAINTENANCE & REPAIRS	18,541	46,261			6.00
7.00	00700	OPERATION OF PLANT	10,975	10,260	184,878		7.00
8.00	00800	LAUNDRY & LINEN SERVICE	1,702	0	0	1,702	8.00
9.00	00900	HOUSEKEEPING	14,073	199	1,023	104	28,708
10.00	01000	DIETARY	87	2,214	11,371	0	0
11.00	01100	CAFETERIA	5,886	994	5,105	0	96
13.00	01300	NURSING ADMINISTRATION	10,477	473	2,427	0	4,582
14.00	01400	CENTRAL SERVICES & SUPPLY	21,531	320	1,646	0	231
15.00	01500	PHARMACY	0	429	2,201	2	226
16.00	01600	MEDICAL RECORDS & LIBRARY	7,135	1,525	7,832	0	96
17.00	01700	SOCIAL SERVICE	4,090	216	1,108	0	160
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	2,955	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	4,271	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	56,020	4,918	25,256	1,381	11,590
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0
41.00	04100	SUBPROVIDER - I&R	0	0	0	0	0
42.00	04200	SUBPROVIDER	0	0	0	0	0
43.00	04300	NURSERY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	18,415	4,126	21,189	208	95
51.00	05100	RECOVERY ROOM	0	0	0	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0
53.00	05300	ANESTHESIOLOGY	2,433	1,173	6,024	1	95
54.00	05400	RADIOLOGY-DIAGNOSTIC	27,283	4,366	22,421	2	1,163
56.00	05600	RADIOISOTOPE	670	213	1,094	0	64
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	12,898	3,494	17,942	3	284
60.01	06001	BLOOD LABORATORY	1,586	0	0	0	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	550	140	718	0	142
65.00	06500	RESPIRATORY THERAPY	6,721	835	4,288	1	24
66.00	06600	PHYSICAL THERAPY	3,534	178	914	0	96
67.00	06700	OCCUPATIONAL THERAPY	13	380	1,950	0	24
68.00	06800	SPEECH PATHOLOGY	4	114	586	0	24
69.00	06900	ELECTROCARDIOLOGY	5,782	315	1,620	0	24
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	33,704	0	0	0	0
74.00	07400	RENAL DIALYSIS	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00	09000	CLINIC	17,480	5,409	27,777	0	0
91.00	09100	EMERGENCY	43,643	3,970	20,386	0	9,692
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0
111.00	11100	ISLET ACQUISITION	0	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	332,459	46,261	184,878	1,702	28,708
NONREIMBURSABLE COST CENTERS							
200.00		Cross Foot Adjustments					
201.00		Negative Cost Centers	0	0	0	0	0
202.00		TOTAL (sum lines 118-201)	332,459	46,261	184,878	1,702	28,708

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140300

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

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Part II
Date/Time Prepared:
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Cost Center Description		DIETARY	CAFETERIA	NURSING ADMINISTRATION	CENTRAL SERVICES & SUPPLY	PHARMACY	
		10.00	11.00	13.00	14.00	15.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	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	25,382					10.00
11.00	01100	0	17,338				11.00
13.00	01300	0	658	85,350			13.00
14.00	01400	0	0	0	33,578		14.00
15.00	01500	0	0	0	2,004	3,516	15.00
16.00	01600	0	789	0	0	0	16.00
17.00	01700	0	247	1,198	0	0	17.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	20,982	8,609	34,330	2,666	297	30.00
31.00	03100	0	0	0	0	0	31.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	0	1,457	14,828	5,519	615	50.00
51.00	05100	0	0	0	0	0	51.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	0	0	0	511	57	53.00
54.00	05400	0	1,097	1,107	5,710	636	54.00
56.00	05600	0	34	0	2	0	56.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	0	1,087	0	10,673	1,188	60.00
60.01	06001	0	0	0	0	0	60.01
62.00	06200	0	145	0	1,632	182	62.00
65.00	06500	0	645	0	932	104	65.00
66.00	06600	0	70	0	88	10	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	0	147	0	44	5	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	0	0	0	0	0	73.00
74.00	07400	0	0	0	4	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	0	0	0	136	15	90.00
91.00	09100	4,400	2,353	33,887	3,657	407	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900	0	0	0	0	0	109.00
110.00	11000	0	0	0	0	0	110.00
111.00	11100	0	0	0	0	0	111.00
118.00		25,382	17,338	85,350	33,578	3,516	118.00
NONREIMBURSABLE COST CENTERS							
200.00							200.00
201.00		0	0	0	0	7,049	201.00
202.00		25,382	17,338	85,350	33,578	10,565	202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 140300

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

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Cost Center Description	MEDICAL RECORDS & LIBRARY	SOCIAL SERVICE	INTERNS & RESIDENTS		Subtotal	
			SERVICES-SALARY & FRINGES	SERVICES-OTHER PRGM COSTS		
			16.00	17.00		21.00
GENERAL SERVICE COST CENTERS						
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT					1.00	
2.00 00200 NEW 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	
15.00 01500 PHARMACY					15.00	
16.00 01600 MEDICAL RECORDS & LIBRARY	25,517				16.00	
17.00 01700 SOCIAL SERVICE	2	8,209			17.00	
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	2,955		21.00	
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0		4,271	22.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS	1,348	3,796			373,535 30.00	
31.00 03100 INTENSIVE CARE UNIT	0	0			0 31.00	
41.00 04100 SUBPROVIDER - IRF	0	0			0 41.00	
42.00 04200 SUBPROVIDER	0	0			0 42.00	
43.00 04300 NURSERY	0	0			0 43.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	126	0			205,470 50.00	
51.00 05100 RECOVERY ROOM	0	0			0 51.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0			0 52.00	
53.00 05300 ANESTHESIOLOGY	0	0			16,617 53.00	
54.00 05400 RADIOLOGY-DIAGNOSTIC	3	0			375,529 54.00	
56.00 05600 RADIOISOTOPE	0	0			3,211 56.00	
57.00 05700 CT SCAN	0	0			0 57.00	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0			0 58.00	
59.00 05900 CARDIAC CATHETERIZATION	0	0			0 59.00	
60.00 06000 LABORATORY	9	0			79,461 60.00	
60.01 06001 BLOOD LABORATORY	0	0			1,586 60.01	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0			5,317 62.00	
65.00 06500 RESPIRATORY THERAPY	0	0			44,386 65.00	
66.00 06600 PHYSICAL THERAPY	0	0			12,750 66.00	
67.00 06700 OCCUPATIONAL THERAPY	0	0			4,375 67.00	
68.00 06800 SPEECH PATHOLOGY	0	0			1,331 68.00	
69.00 06900 ELECTROCARDIOLOGY	0	0			44,515 69.00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			0 71.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0			0 72.00	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0			33,704 73.00	
74.00 07400 RENAL DIALYSIS	0	0			4 74.00	
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0	0			0 88.00	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0			0 89.00	
90.00 09000 CLINIC	14,464	4,413			101,915 90.00	
91.00 09100 EMERGENCY	9,565	0			155,801 91.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)					92.00	
OTHER REIMBURSABLE COST CENTERS						
99.10 09910 CORF	0	0			0 99.10	
SPECIAL PURPOSE COST CENTERS						
109.00 10900 PANCREAS ACQUISITION	0	0			0 109.00	
110.00 11000 INTESTINAL ACQUISITION	0	0			0 110.00	
111.00 11100 ISLET ACQUISITION	0	0			0 111.00	
118.00	SUBTOTALS (SUM OF LINES 1-117)	25,517	8,209	0	0	1,459,507 118.00
NONREIMBURSABLE COST CENTERS						
200.00	Cross Foot Adjustments			2,955	4,271	7,226 200.00
201.00	Negative Cost Centers	0	0	0	0	7,049 201.00
202.00	TOTAL (sum lines 118-201)	25,517	8,209	2,955	4,271	1,473,782 202.00

ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 140300	Period: From 12/01/2011 To 11/30/2012	Worksheet B Part II Date/Time Prepared: 4/29/2013 11:36 am
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Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total	
		25.00	26.00	
GENERAL SERVICE COST CENTERS				
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT		1.00
2.00	00200	NEW 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
15.00	01500	PHARMACY		15.00
16.00	01600	MEDICAL RECORDS & LIBRARY		16.00
17.00	01700	SOCIAL SERVICE		17.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD		21.00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD		22.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000	ADULTS & PEDIATRICS	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	41.00
42.00	04200	SUBPROVIDER	0	42.00
43.00	04300	NURSERY	0	43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000	OPERATING ROOM	0	50.00
51.00	05100	RECOVERY ROOM	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	52.00
53.00	05300	ANESTHESIOLOGY	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	54.00
56.00	05600	RADIOISOTOPE	0	56.00
57.00	05700	CT SCAN	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	59.00
60.00	06000	LABORATORY	0	60.00
60.01	06001	BLOOD LABORATORY	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	65.00
66.00	06600	PHYSICAL THERAPY	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	73.00
74.00	07400	RENAL DIALYSIS	0	74.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800	RURAL HEALTH CLINIC	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	89.00
90.00	09000	CLINIC	0	90.00
91.00	09100	EMERGENCY	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	92.00
OTHER REIMBURSABLE COST CENTERS				
99.10	09910	CORF	0	99.10
SPECIAL PURPOSE COST CENTERS				
109.00	10900	PANCREAS ACQUISITION	0	109.00
110.00	11000	INTESTINAL ACQUISITION	0	110.00
111.00	11100	ISLET ACQUISITION	0	111.00
118.00		SUBTOTALS (SUM OF LINES 1-117)	0	118.00
NONREIMBURSABLE COST CENTERS				
200.00		Cross Foot Adjustments	0	200.00
201.00		Negative Cost Centers	0	201.00
202.00		TOTAL (sum lines 118-201)	0	202.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140300

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

Worksheet B-1
Date/Time Prepared:
4/29/2013 11:36 am

Cost Center Description	CAPITAL RELATED COSTS			EMPLOYEE BENEFITS (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUIP (DOLLAR VALUE)					
	1.00	2.00	4.00				
GENERAL SERVICE COST CENTERS							
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT	369,623						1.00
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP		2,889,552					2.00
4.00 00400 EMPLOYEE BENEFITS	3,927	0	34,512,108				4.00
5.00 00500 ADMINISTRATIVE & GENERAL	104,418	600,022	3,664,009	-17,800,757		49,603,925	5.00
6.00 00600 MAINTENANCE & REPAIRS	1,294	67,717	1,075,886	0		2,766,430	6.00
7.00 00700 OPERATION OF PLANT	57,653	280,506	826,591	0		1,637,589	7.00
8.00 00800 LAUNDRY & LINEN SERVICE	0	0	0	0		254,003	8.00
9.00 00900 HOUSEKEEPING	1,120	31,072	1,371,035	0		2,099,763	9.00
10.00 01000 DIETARY	12,444	0	0	0		13,049	10.00
11.00 01100 CAFETERIA	5,587	0	0	0		878,257	11.00
13.00 01300 NURSING ADMINISTRATION	2,656	164,594	895,711	0		1,563,216	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	1,801	20,929	0	0		3,212,696	14.00
15.00 01500 PHARMACY	2,409	8,817	0	238,052		0	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	8,571	0	701,930	0		1,064,589	16.00
17.00 01700 SOCIAL SERVICE	1,213	0	435,763	0		610,219	17.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0		440,920	21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0		637,243	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00 03000 ADULTS & PEDIATRICS	27,640	450,325	7,952,990	0		8,356,711	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0	0	0		0	31.00
41.00 04100 SUBPROVIDER - IRF	0	0	0	0		0	41.00
42.00 04200 SUBPROVIDER	0	0	0	0		0	42.00
43.00 04300 NURSERY	0	0	0	0		0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	23,189	299,667	2,803,202	0		2,747,655	50.00
51.00 05100 RECOVERY ROOM	0	0	0	0		0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0		0	52.00
53.00 05300 ANESTHESIOLOGY	6,593	0	1,115,812	0		363,094	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	24,538	740,148	2,225,150	0		4,070,828	54.00
56.00 05600 RADIOISOTOPE	1,197	0	73,773	0		99,911	56.00
57.00 05700 CT SCAN	0	0	0	0		0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0		0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	0		0	59.00
60.00 06000 LABORATORY	19,636	33,930	1,722,339	0		1,924,446	60.00
60.01 06001 BLOOD LABORATORY	0	0	0	0		236,596	60.01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	786	2,677	236,596	0		81,999	62.00
65.00 06500 RESPIRATORY THERAPY	4,693	67,599	737,147	0		1,002,803	65.00
66.00 06600 PHYSICAL THERAPY	1,000	17,713	155,982	0		527,369	66.00
67.00 06700 OCCUPATIONAL THERAPY	2,134	0	0	0		2,008	67.00
68.00 06800 SPEECH PATHOLOGY	641	0	0	0		603	68.00
69.00 06900 ELECTROCARDIOLOGY	1,773	89,362	822,265	0		862,744	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	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		5,028,958	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	0		1	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00 08800 RURAL HEALTH CLINIC	0	0	0	0		0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0		0	89.00
90.00 09000 CLINIC	30,400	9,278	0	0		2,608,243	90.00
91.00 09100 EMERGENCY	22,310	5,196	7,695,927	0		6,511,982	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)							92.00
OTHER REIMBURSABLE COST CENTERS							
99.10 09910 CORF	0	0	0	0		0	99.10
SPECIAL PURPOSE COST CENTERS							
109.00 10900 PANCREAS ACQUISITION	0	0	0	0		0	109.00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0		0	110.00
111.00 11100 ISLET ACQUISITION	0	0	0	0		0	111.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	369,623	2,889,552	34,512,108	-17,562,705		49,603,925	118.00
NONREIMBURSABLE COST CENTERS							
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)	347,808	1,125,974	11,700,984			17,800,757	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	0.940980	0.389671	0.339040			0.358858	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)			3,695			332,459	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)			0.000107			0.006702	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140300

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

Worksheet B-1

Date/Time Prepared:
4/29/2013 11:36 am

Cost Center Description		MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPING (HOURS OF SERVICE)	DIETARY (MEALS SERVED)	
		6.00	7.00	8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS							
1.00	00100	NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200	NEW 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	259,984				6.00
7.00	00700	OPERATION OF PLANT	57,653	202,331			7.00
8.00	00800	LAUNDRY & LINEN SERVICE	0	0	370,644		8.00
9.00	00900	HOUSEKEEPING	1,120	1,120	22,614	34,941	9.00
10.00	01000	DIETARY	12,444	12,444	0	0	21,142
11.00	01100	CAFETERIA	5,587	5,587	0	117	0
13.00	01300	NURSING ADMINISTRATION	2,656	2,656	0	5,577	0
14.00	01400	CENTRAL SERVICES & SUPPLY	1,801	1,801	0	281	0
15.00	01500	PHARMACY	2,409	2,409	407	275	0
16.00	01600	MEDICAL RECORDS & LIBRARY	8,571	8,571	0	117	0
17.00	01700	SOCIAL SERVICE	1,213	1,213	0	195	0
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	27,640	27,640	300,588	14,105	17,477
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0
42.00	04200	SUBPROVIDER	0	0	0	0	0
43.00	04300	NURSERY	0	0	0	0	0
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	23,189	23,189	45,300	116	0
51.00	05100	RECOVERY ROOM	0	0	0	0	0
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0
53.00	05300	ANESTHESIOLOGY	6,593	6,593	110	116	0
54.00	05400	RADIOLOGY-DIAGNOSTIC	24,538	24,538	516	1,416	0
56.00	05600	RADIOISOTOPE	1,197	1,197	0	78	0
57.00	05700	CT SCAN	0	0	0	0	0
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0
60.00	06000	LABORATORY	19,636	19,636	594	346	0
60.01	06001	BLOOD LABORATORY	0	0	0	0	0
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	786	786	61	173	0
65.00	06500	RESPIRATORY THERAPY	4,693	4,693	266	29	0
66.00	06600	PHYSICAL THERAPY	1,000	1,000	16	117	0
67.00	06700	OCCUPATIONAL THERAPY	2,134	2,134	0	29	0
68.00	06800	SPEECH PATHOLOGY	641	641	16	29	0
69.00	06900	ELECTROCARDIOLOGY	1,773	1,773	94	29	0
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	0
74.00	07400	RENAL DIALYSIS	0	0	0	0	0
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0
90.00	09000	CLINIC	30,400	30,400	62	0	0
91.00	09100	EMERGENCY	22,310	22,310	0	11,796	3,665
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)					
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0	0	0
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0	0	0
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0
111.00	11100	ISLET ACQUISITION	0	0	0	0	0
118.00		SUBTOTALS (SUM OF LINES 1-117)	259,984	202,331	370,644	34,941	21,142
NONREIMBURSABLE COST CENTERS							
200.00		Cross Foot Adjustments					200.00
201.00		Negative Cost Centers					201.00
202.00		Cost to be allocated (per Wkst. B, Part I)	3,759,186	3,058,875	345,154	2,907,465	385,794
203.00		Unit cost multiplier (Wkst. B, Part I)	14.459297	15.118173	0.931228	83.210698	18.247753
204.00		Cost to be allocated (per Wkst. B, Part II)	46,261	184,878	1,702	28,708	25,382
205.00		Unit cost multiplier (Wkst. B, Part II)	0.177938	0.913740	0.004592	0.821614	1.200549

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140300

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

Worksheet B-1

Date/Time Prepared:
4/29/2013 11:36 am

Cost Center Description		CAFETERIA (MEALS SERVED)	NURSING ADMINISTRATION (DIRECT NURSING HRS)	CENTRAL SERVICES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE COST CENTERS							
1.00	00100						1.00
2.00	00200						2.00
4.00	00400						4.00
5.00	00500						5.00
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	89,380					11.00
13.00	01300	3,392	162,663				13.00
14.00	01400	0	0	1,909,629			14.00
15.00	01500	0	0	113,973	1,795,656		15.00
16.00	01600	4,066	0	0	0	24,671	16.00
17.00	01700	1,272	2,283	0	0	0	17.00
21.00	02100	0	0	0	0	0	21.00
22.00	02200	0	0	0	0	0	22.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	44,390	65,428	151,636	151,636	1,303	30.00
31.00	03100	0	0	0	0	0	31.00
41.00	04100	0	0	0	0	0	41.00
42.00	04200	0	0	0	0	0	42.00
43.00	04300	0	0	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	7,512	28,259	313,867	313,867	122	50.00
51.00	05100	0	0	0	0	0	51.00
52.00	05200	0	0	0	0	0	52.00
53.00	05300	0	0	29,072	29,072	0	53.00
54.00	05400	5,654	2,110	324,733	324,733	3	54.00
56.00	05600	173	0	134	134	0	56.00
57.00	05700	0	0	0	0	0	57.00
58.00	05800	0	0	0	0	0	58.00
59.00	05900	0	0	0	0	0	59.00
60.00	06000	5,602	0	606,953	606,953	9	60.00
60.01	06001	0	0	0	0	0	60.01
62.00	06200	749	0	92,827	92,827	0	62.00
65.00	06500	3,325	0	52,978	52,978	0	65.00
66.00	06600	359	0	5,026	5,026	0	66.00
67.00	06700	0	0	0	0	0	67.00
68.00	06800	0	0	0	0	0	68.00
69.00	06900	758	0	2,480	2,480	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	0	0	0	0	0	73.00
74.00	07400	0	0	234	234	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	0	0	0	0	0	88.00
89.00	08900	0	0	0	0	0	89.00
90.00	09000	0	0	7,740	7,740	13,984	90.00
91.00	09100	12,128	64,583	207,976	207,976	9,248	91.00
92.00	09200						92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	0	0	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900	0	0	0	0	0	109.00
110.00	11000	0	0	0	0	0	110.00
111.00	11100	0	0	0	0	0	111.00
118.00		89,380	162,663	1,909,629	1,795,656	24,671	118.00
NONREIMBURSABLE COST CENTERS							
200.00							200.00
201.00							201.00
202.00		1,368,412	2,718,745	4,442,249	121,590	1,772,121	202.00
203.00		15.310047	16.713973	2.326237	0.067713	71.830124	203.00
204.00		17,338	85,350	33,578	10,565	25,517	204.00
205.00		0.193981	0.524704	0.017584	0.001958	1.034291	205.00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 140300

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

Worksheet B-1
Date/Time Prepared:
4/29/2013 11:36 am

Cost Center Description	SOCIAL SERVICE (TIME SPENT)	INTERNS & RESIDENTS		
		SERVICES-SALARY & FRINGES (ASSIGNED TIME)	SERVICES-OTHER PRGM COSTS (ASSIGNED TIME)	
		17.00	21.00	
GENERAL SERVICE COST CENTERS				
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00 00200 NEW 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
15.00 01500 PHARMACY				15.00
16.00 01600 MEDICAL RECORDS & LIBRARY				16.00
17.00 01700 SOCIAL SERVICE	7,671			17.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	9,834		21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0		9,834	22.00
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00 03000 ADULTS & PEDIATRICS	3,547	4,482	4,482	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0	0	31.00
41.00 04100 SUBPROVIDER - IRF	0	0	0	41.00
42.00 04200 SUBPROVIDER	0	0	0	42.00
43.00 04300 NURSERY	0	0	0	43.00
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0	439	439	50.00
51.00 05100 RECOVERY ROOM	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	55	55	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	0	54.00
56.00 05600 RADIOISOTOPE	0	0	0	56.00
57.00 05700 CT SCAN	0	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	0	59.00
60.00 06000 LABORATORY	0	0	0	60.00
60.01 06001 BLOOD LABORATORY	0	0	0	60.01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	62.00
65.00 06500 RESPIRATORY THERAPY	0	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC	0	0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	89.00
90.00 09000 CLINIC	4,124	663	663	90.00
91.00 09100 EMERGENCY	0	4,195	4,195	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)				92.00
OTHER REIMBURSABLE COST CENTERS				
99.10 09910 CORF	0	0	0	99.10
SPECIAL PURPOSE COST CENTERS				
109.00 10900 PANCREAS ACQUISITION	0	0	0	109.00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	110.00
111.00 11100 ISLET ACQUISITION	0	0	0	111.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	7,671	9,834	9,834	118.00
NONREIMBURSABLE COST CENTERS				
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)	939,080	599,148	865,923	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	122.419502	60.926174	88.053996	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	8,209	2,955	4,271	204.00
205.00 Unit cost multiplier (Wkst. B, Part II)	1.070134	0.300488	0.434310	205.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140300

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

Worksheet C
Part I
Date/Time Prepared:
4/29/2013 11:36 am

		Title XVIII		Hospital		PPS	
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Costs				
			Total Costs	RCE	Total Costs		
				Disallowance			
	1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	16,609,613		16,609,613	419,803	17,029,416	30.00
31.00	03100 INTENSIVE CARE UNIT	0		0	0	0	31.00
41.00	04100 SUBPROVIDER - I RF	0		0	0	0	41.00
42.00	04200 SUBPROVIDER	0		0	0	0	42.00
43.00	04300 NURSERY	0		0	0	0	43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	5,818,856		5,818,856	93,943	5,912,799	50.00
51.00	05100 RECOVERY ROOM	0		0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53.00	05300 ANESTHESIOLOGY	767,748		767,748	264,123	1,031,871	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	7,275,195		7,275,195	0	7,275,195	54.00
56.00	05600 RADIOISOTOPE	180,629		180,629	0	180,629	56.00
57.00	05700 CT SCAN	0		0	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0		0	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0		0	0	0	59.00
60.00	06000 LABORATORY	4,764,604		4,764,604	0	4,764,604	60.00
60.01	06001 BLOOD LABORATORY	321,500		321,500	0	321,500	60.01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	382,816		382,816	0	382,816	62.00
65.00	06500 RESPIRATORY THERAPY	1,681,867	0	1,681,867	0	1,681,867	65.00
66.00	06600 PHYSICAL THERAPY	773,476	0	773,476	0	773,476	66.00
67.00	06700 OCCUPATIONAL THERAPY	68,260	0	68,260	0	68,260	67.00
68.00	06800 SPEECH PATHOLOGY	22,206	0	22,206	0	22,206	68.00
69.00	06900 ELECTROCARDIOLOGY	1,244,831		1,244,831	80,445	1,325,276	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	6,833,640		6,833,640	0	6,833,640	73.00
74.00	07400 RENAL DIALYSIS	561		561	0	561	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0		0	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	89.00
90.00	09000 CLINIC	5,971,306		5,971,306	0	5,971,306	90.00
91.00	09100 EMERGENCY	12,984,451		12,984,451	182,598	13,167,049	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	723,927		723,927	0	723,927	92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910 CORF	0		0	0	0	99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900 PANCREAS ACQUISITION	0		0	0	0	109.00
110.00	11000 INTESTINAL ACQUISITION	0		0	0	0	110.00
111.00	11100 ISLET ACQUISITION	0		0	0	0	111.00
200.00	Subtotal (see instructions)	66,425,486	0	66,425,486	1,040,912	67,466,398	200.00
201.00	Less Observation Beds	723,927		723,927	0	723,927	201.00
202.00	Total (see instructions)	65,701,559	0	65,701,559	1,040,912	66,742,471	202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 140300

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

Worksheet C
Part I
Date/Time Prepared:
4/29/2013 11:36 am

		Title XVIII			Hospital	PPS	
Cost Center Description	Charges			Cost or Other Ratio	TEFRA Inpatient Ratio		
	Inpatient	Outpatient	Total (col. 6 + col. 7)				
	6.00	7.00	8.00				9.00
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000	ADULTS & PEDIATRICS	5,819,408		5,819,408		30.00
31.00	03100	INTENSIVE CARE UNIT	0		0		31.00
41.00	04100	SUBPROVIDER - IRF	0		0		41.00
42.00	04200	SUBPROVIDER	0		0		42.00
43.00	04300	NURSERY	0		0		43.00
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	2,314,254	10,642,008	12,956,262	0.449115	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0.000000	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0.000000	52.00
53.00	05300	ANESTHESIOLOGY	881,754	3,755,001	4,636,755	0.165579	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	335,375	5,754,683	6,090,058	1.194602	54.00
56.00	05600	RADIOISOTOPE	822,331	661,268	1,483,599	0.121751	56.00
57.00	05700	CT SCAN	965,893	5,600,586	6,566,479	0.000000	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0.000000	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0.000000	59.00
60.00	06000	LABORATORY	1,664,926	7,836,654	9,501,580	0.501454	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0.000000	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	49,264	87,676	136,940	2.795502	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0.000000	65.00
66.00	06600	PHYSICAL THERAPY	12,780	851,204	863,984	0.895243	66.00
67.00	06700	OCCUPATIONAL THERAPY	780	266,115	266,895	0.255756	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0.000000	68.00
69.00	06900	ELECTROCARDIOLOGY	450,088	1,371,646	1,821,734	0.683322	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	29,739	1,109,279	1,139,018	0.000000	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0.000000	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	3,702,583	3,707,195	7,409,778	0.922246	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0.000000	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0		88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89.00
90.00	09000	CLINIC	84,562	6,213,777	6,298,339	0.948076	90.00
91.00	09100	EMERGENCY	1,027,521	14,278,592	15,306,113	0.848318	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	96,680	693,572	790,252	0.916071	92.00
OTHER REIMBURSABLE COST CENTERS							
99.10	09910	CORF	0	0	0		99.10
SPECIAL PURPOSE COST CENTERS							
109.00	10900	PANCREAS ACQUISITION	0	0	0		109.00
110.00	11000	INTESTINAL ACQUISITION	0	0	0		110.00
111.00	11100	ISLET ACQUISITION	0	0	0		111.00
200.00		Subtotal (see instructions)	18,257,938	62,829,256	81,087,194		200.00
201.00		Less Observation Beds					201.00
202.00		Total (see instructions)	18,257,938	62,829,256	81,087,194		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 140300	Period: From 12/01/2011 To 11/30/2012	Worksheet C Part I Date/Time Prepared: 4/29/2013 11:36 am
Cost Center Description		PPS Inpatient Ratio 11.00	Title XVIII	Hospital PPS
INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDIATRICS			30.00
31.00	03100 INTENSIVE CARE UNIT			31.00
41.00	04100 SUBPROVIDER - IRF			41.00
42.00	04200 SUBPROVIDER			42.00
43.00	04300 NURSERY			43.00
ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0.456366		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	0.222542		53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1.194602		54.00
56.00	05600 RADIOISOTOPE	0.121751		56.00
57.00	05700 CT SCAN	0.000000		57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000		58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000		59.00
60.00	06000 LABORATORY	0.501454		60.00
60.01	06001 BLOOD LABORATORY	0.000000		60.01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	2.795502		62.00
65.00	06500 RESPIRATORY THERAPY	0.000000		65.00
66.00	06600 PHYSICAL THERAPY	0.895243		66.00
67.00	06700 OCCUPATIONAL THERAPY	0.255756		67.00
68.00	06800 SPEECH PATHOLOGY	0.000000		68.00
69.00	06900 ELECTROCARDIOLOGY	0.727481		69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.922246		73.00
74.00	07400 RENAL DIALYSIS	0.000000		74.00
OUTPATIENT SERVICE COST CENTERS				
88.00	08800 RURAL HEALTH CLINIC			88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER			89.00
90.00	09000 CLINIC	0.948076		90.00
91.00	09100 EMERGENCY	0.860248		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.916071		92.00
OTHER REIMBURSABLE COST CENTERS				
99.10	09910 CORF			99.10
SPECIAL PURPOSE COST CENTERS				
109.00	10900 PANCREAS ACQUISITION			109.00
110.00	11000 INTESTINAL ACQUISITION			110.00
111.00	11100 ISLET ACQUISITION			111.00
200.00	Subtotal (see instructions)			200.00
201.00	Less Observation Beds			201.00
202.00	Total (see instructions)			202.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 140300		Period: From 12/01/2011 To 11/30/2012		Worksheet D Part I Date/Time Prepared: 4/29/2013 11:36 am	
Cost Center Description		Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col. 2)	Total Patient Days	Per Diem (col. 3 / col. 4)	PPS
		1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30.00	03000 ADULTS & PEDIATRICS	373,535	0	373,535	6,469	57.74	30.00
31.00	03100 INTENSIVE CARE UNIT	0	0	0	0	0.00	31.00
41.00	04100 SUBPROVIDER - IRF	0	0	0	0	0.00	41.00
42.00	04200 SUBPROVIDER	0	0	0	0	0.00	42.00
43.00	04300 NURSERY	0	0	0	0	0.00	43.00
200.00	Total (lines 30-199)	373,535		373,535	6,469		200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL COSTS		Provider CCN: 140300	Period: From 12/01/2011 To 11/30/2012	Worksheet D Part I Date/Time Prepared: 4/29/2013 11:36 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	896	51,735	30.00
31.00	03100 INTENSIVE CARE UNIT	0	0	31.00
41.00	04100 SUBPROVIDER - IRF	0	0	41.00
42.00	04200 SUBPROVIDER	0	0	42.00
43.00	04300 NURSERY	0	0	43.00
200.00	Total (lines 30-199)	896	51,735	200.00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS		Provider CCN: 140300	Period: From 12/01/2011 To 11/30/2012	Worksheet D Part II Date/Time Prepared: 4/29/2013 11:36 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	205,470	12,956,262	0.015859	49,242	781	50.00
51.00	05100 RECOVERY ROOM	0	0	0.000000	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0	0	52.00
53.00	05300 ANESTHESIOLOGY	16,617	4,636,755	0.003584	14,048	50	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	375,529	6,090,058	0.061663	177,388	10,938	54.00
56.00	05600 RADIOISOTOPE	3,211	1,483,599	0.002164	109,787	238	56.00
57.00	05700 CT SCAN	0	6,566,479	0.000000	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0	0	0.000000	0	0	59.00
60.00	06000 LABORATORY	79,461	9,501,580	0.008363	225,713	1,888	60.00
60.01	06001 BLOOD LABORATORY	1,586	0	0.000000	0	0	60.01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	5,317	136,940	0.038827	3,008	117	62.00
65.00	06500 RESPIRATORY THERAPY	44,386	0	0.000000	0	0	65.00
66.00	06600 PHYSICAL THERAPY	12,750	863,984	0.014757	3,588	53	66.00
67.00	06700 OCCUPATIONAL THERAPY	4,375	266,895	0.016392	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	1,331	0	0.000000	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	44,515	1,821,734	0.024436	71,284	1,742	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,139,018	0.000000	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	33,704	7,409,778	0.004549	495,645	2,255	73.00
74.00	07400 RENAL DIALYSIS	4	0	0.000000	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800 RURAL HEALTH CLINIC	0	0	0.000000	0	0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0	0	89.00
90.00	09000 CLINIC	101,915	6,298,339	0.016181	611	10	90.00
91.00	09100 EMERGENCY	155,801	15,306,113	0.010179	77,568	790	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	15,879	790,252	0.020094	0	0	92.00
200.00	Total (lines 50-199)	1,101,851	75,267,786		1,227,882	18,862	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS			Provider CCN: 140300		Period: From 12/01/2011 To 11/30/2012		Worksheet D Part III Date/Time Prepared: 4/29/2013 11:36 am	
Cost Center Description			Nursing School	Allied Health Cost	All Other Medical Education Cost	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
			1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30.00	03000	ADULTS & PEDIATRICS	0	0	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0	0	0	0	31.00
41.00	04100	SUBPROVIDER - IRF	0	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0	0	0	0	42.00
43.00	04300	NURSERY	0	0	0	0	0	43.00
200.00		Total (lines 30-199)	0	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140300	Period: From 12/01/2011 To 11/30/2012	Worksheet D Part III Date/Time Prepared: 4/29/2013 11:36 am
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Cost Center Description	Title XVIII					Hospital		PPS	
	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8)	PSA Adj. Nursing School				
	6.00	7.00	8.00	9.00	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS									
30.00	03000	ADULTS & PEDIATRICS	6,469	0.00	896	0	0	0	30.00
31.00	03100	INTENSIVE CARE UNIT	0	0.00	0	0	0	0	31.00
41.00	04100	SUBPROVIDER - I RF	0	0.00	0	0	0	0	41.00
42.00	04200	SUBPROVIDER	0	0.00	0	0	0	0	42.00
43.00	04300	NURSERY	0	0.00	0	0	0	0	43.00
200.00		Total (lines 30-199)	6,469		896	0	0	0	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS		Provider CCN: 140300		Period: From 12/01/2011 To 11/30/2012		Worksheet D Part III Date/Time Prepared: 4/29/2013 11:36 am	
Cost Center Description		PSA Adj . Allied Health Cost	PSA Adj . All Other Medical Education Cost	Title XVIII	Hospital	PPS	
		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
41.00	04100	SUBPROVIDER - I RF	0	0			41.00
42.00	04200	SUBPROVIDER	0	0			42.00
43.00	04300	NURSERY	0	0			43.00
200.00		Total (lines 30-199)	0	0			200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140300

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

Worksheet D
Part IV
Date/Time Prepared:
4/29/2013 11:36 am

Cost Center Description		Title XVIII				Hospital	PPS
		Non Physician Anesthetist Cost	Nursing School	Allied Health	All Other Medical Education Cost	Total Cost (sum of col 1 through col 4)	
		1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00	05000	OPERATING ROOM	0	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	59.00
60.00	06000	LABORATORY	0	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS							
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	89.00
90.00	09000	CLINIC	0	0	0	0	90.00
91.00	09100	EMERGENCY	0	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140300	Period: From 12/01/2011 To 11/30/2012	Worksheet D Part IV Date/Time Prepared: 4/29/2013 11:36 am
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Cost Center Description		Total Outpatient Cost (sum of col. 2, 3 and 4)	Total Charges (from Wkst. C, Part I, col. 8)	Ratio of Cost to Charges (col. 5 ÷ col. 7)	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	12,956,262	0.000000	0.000000	49,242	50.00
51.00	05100	RECOVERY ROOM	0	0	0.000000	0.000000	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0.000000	0.000000	0	52.00
53.00	05300	ANESTHESIOLOGY	0	4,636,755	0.000000	0.000000	14,048	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	6,090,058	0.000000	0.000000	177,388	54.00
56.00	05600	RADIOISOTOPE	0	1,483,599	0.000000	0.000000	109,787	56.00
57.00	05700	CT SCAN	0	6,566,479	0.000000	0.000000	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.000000	0.000000	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0.000000	0.000000	0	59.00
60.00	06000	LABORATORY	0	9,501,580	0.000000	0.000000	225,713	60.00
60.01	06001	BLOOD LABORATORY	0	0	0.000000	0.000000	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	136,940	0.000000	0.000000	3,008	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0.000000	0.000000	0	65.00
66.00	06600	PHYSICAL THERAPY	0	863,984	0.000000	0.000000	3,588	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	266,895	0.000000	0.000000	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	1,821,734	0.000000	0.000000	71,284	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	1,139,018	0.000000	0.000000	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0.000000	0.000000	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	7,409,778	0.000000	0.000000	495,645	73.00
74.00	07400	RENAL DIALYSIS	0	0	0.000000	0.000000	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	0.000000	0	89.00
90.00	09000	CLINIC	0	6,298,339	0.000000	0.000000	611	90.00
91.00	09100	EMERGENCY	0	15,306,113	0.000000	0.000000	77,568	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	790,252	0.000000	0.000000	0	92.00
200.00		Total (Lines 50-199)	0	75,267,786			1,227,882	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 140300

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

Worksheet D
Part IV
Date/Time Prepared:
4/29/2013 11:36 am

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	592,863	0	0	0	50.00
51.00	05100	RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300	ANESTHESIOLOGY	0	0	0	0	0	53.00
54.00	05400	RADIOLOGY-DIAGNOSTIC	0	645,388	0	0	0	54.00
56.00	05600	RADIOISOTOPE	0	3,870	0	0	0	56.00
57.00	05700	CT SCAN	0	0	0	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	0	0	0	59.00
60.00	06000	LABORATORY	0	21,341	0	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	0	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	5,145	0	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	0	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	788	0	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	0	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	0	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	66,924	0	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	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	139,315	0	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	0	0	0	74.00
OUTPATIENT SERVICE COST CENTERS								
88.00	08800	RURAL HEALTH CLINIC	0	0	0	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90.00	09000	CLINIC	0	600,408	0	0	0	90.00
91.00	09100	EMERGENCY	0	646,406	0	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	0	0	92.00
200.00		Total (lines 50-199)	0	2,722,448	0	0	0	200.00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 140300	Period: From 12/01/2011 To 11/30/2012	Worksheet D Part IV Date/Time Prepared: 4/29/2013 11:36 am
	Title XVIII	Hospital	PPS

Cost Center Description	PSA Adj . Allied Health	PSA Adj . All Other Medical Education Cost	
	23.00	24.00	
ANCILLARY SERVICE COST CENTERS			
50.00 05000 OPERATING ROOM	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	52.00
53.00 05300 ANESTHESIOLOGY	0	0	53.00
54.00 05400 RADIOLOGY-DIAGNOSTIC	0	0	54.00
56.00 05600 RADIOISOTOPE	0	0	56.00
57.00 05700 CT SCAN	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00 05900 CARDIAC CATHETERIZATION	0	0	59.00
60.00 06000 LABORATORY	0	0	60.00
60.01 06001 BLOOD LABORATORY	0	0	60.01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.00
65.00 06500 RESPIRATORY THERAPY	0	0	65.00
66.00 06600 PHYSICAL THERAPY	0	0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	68.00
69.00 06900 ELECTROCARDIOLOGY	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	74.00
OUTPATIENT SERVICE COST CENTERS			
88.00 08800 RURAL HEALTH CLINIC	0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00 09000 CLINIC	0	0	90.00
91.00 09100 EMERGENCY	0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00 Total (lines 50-199)	0	0	200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 140300	Period: From 12/01/2011 To 11/30/2012	Worksheet D Part V Date/Time Prepared: 4/29/2013 11:36 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	0.449115	592,863	0	0	266,264 50.00
51.00	05100 RECOVERY ROOM	0.000000	0	0	0	0 51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	0	0 52.00
53.00	05300 ANESTHESIOLOGY	0.165579	0	0	0	0 53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1.194602	645,388	0	0	770,982 54.00
56.00	05600 RADIOISOTOPE	0.121751	3,870	0	0	471 56.00
57.00	05700 CT SCAN	0.000000	0	0	0	0 57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	0	0 58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	0	0 59.00
60.00	06000 LABORATORY	0.501454	21,341	0	0	10,702 60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	0	0 60.01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	2.795502	5,145	0	0	14,383 62.00
65.00	06500 RESPIRATORY THERAPY	0.000000	0	0	0	0 65.00
66.00	06600 PHYSICAL THERAPY	0.895243	788	0	0	705 66.00
67.00	06700 OCCUPATIONAL THERAPY	0.255756	0	0	0	0 67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	0	0 68.00
69.00	06900 ELECTROCARDIOLOGY	0.683322	66,924	0	0	45,731 69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	0	0 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	0	0 72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.922246	139,315	0	0	128,483 73.00
74.00	07400 RENAL DIALYSIS	0.000000	0	0	0	0 74.00
OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0.000000				0 88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000				0 89.00
90.00	09000 CLINIC	0.948076	600,408	0	0	569,232 90.00
91.00	09100 EMERGENCY	0.848318	646,406	0	0	548,358 91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.916071	0	0	0	0 92.00
200.00	Subtotal (see instructions)		2,722,448	0	0	2,355,311 200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges			0	0	0 201.00
202.00	Net Charges (line 200 +/- line 201)		2,722,448	0	0	2,355,311 202.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST		Provider CCN: 140300	Period: From 12/01/2011 To 11/30/2012	Worksheet D Part V Date/Time Prepared: 4/29/2013 11:36 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
56.00	05600	RADIOISOTOPE	0	0	56.00
57.00	05700	CT SCAN	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0	0	58.00
59.00	05900	CARDIAC CATHETERIZATION	0	0	59.00
60.00	06000	LABORATORY	0	0	60.00
60.01	06001	BLOOD LABORATORY	0	0	60.01
62.00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	62.00
65.00	06500	RESPIRATORY THERAPY	0	0	65.00
66.00	06600	PHYSICAL THERAPY	0	0	66.00
67.00	06700	OCCUPATIONAL THERAPY	0	0	67.00
68.00	06800	SPEECH PATHOLOGY	0	0	68.00
69.00	06900	ELECTROCARDIOLOGY	0	0	69.00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	71.00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	72.00
73.00	07300	DRUGS CHARGED TO PATIENTS	0	0	73.00
74.00	07400	RENAL DIALYSIS	0	0	74.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800	RURAL HEALTH CLINIC	0	0	88.00
89.00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	89.00
90.00	09000	CLINIC	0	0	90.00
91.00	09100	EMERGENCY	0	0	91.00
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0	92.00
200.00		Subtotal (see instructions)	0	0	200.00
201.00		Less PBP Clinic Lab. Services-Program Only Charges	0		201.00
202.00		Net Charges (line 200 +/- line 201)	0	0	202.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140300	Period: From 12/01/2011 To 11/30/2012	Worksheet D-1 Date/Time Prepared: 4/29/2013 11:36 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)		6,469	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		6,469	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.		1,106	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed days)		5,088	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)		896	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)		17,029,416	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)		17,029,416	27.00
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed charges)		698,714	28.00
29.00	Private room charges (excluding swing-bed charges)		305,502	29.00
30.00	Semi-private room charges (excluding swing-bed charges)		393,212	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		24.372513	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)		276.22	32.00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)		77.28	33.00
34.00	Average per diem private room charge differential (line 32 minus line 33) (see instructions)		198.94	34.00
35.00	Average per diem private room cost differential (line 34 x line 31)		4,848.67	35.00
36.00	Private room cost differential adjustment (line 3 x line 35)		5,362,629	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)		11,666,787	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)		2,632.46	38.00
39.00	Program general inpatient routine service cost (line 9 x line 38)		2,358,684	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)		2,358,684	41.00

COMPUTATION OF INPATIENT OPERATING COST			Provider CCN: 140300	Period: From 12/01/2011 To 11/30/2012	Worksheet D-1 Date/Time Prepared: 4/29/2013 11:36 am	
Cost Center Description			Title XVIII		Hospital	PPS
	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)	0	0	0.00	0	42.00
Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	43.00
44.00	CORONARY CARE UNIT					44.00
45.00	BURN INTENSIVE CARE UNIT					45.00
46.00	SURGICAL INTENSIVE CARE UNIT					46.00
47.00	OTHER SPECIAL CARE (SPECIFY)					47.00
Cost Center Description						
					1.00	
48.00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)				951,951	48.00
49.00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)				3,310,635	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)				51,735	50.00
51.00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)				18,862	51.00
52.00	Total Program excludable cost (sum of lines 50 and 51)				70,597	52.00
53.00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)				3,240,038	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)				275	87.00
88.00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)				2,632.46	88.00
89.00	Observation bed cost (line 87 x line 88) (see instructions)				723,927	89.00

COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 140300		Period: From 12/01/2011 To 11/30/2012		Worksheet D-1 Date/Time Prepared: 4/29/2013 11:36 am	
Cost Center Description		Cost	Routine Cost (from line 27)	column 1 + column 2	Total Observation Bed Cost (from line 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions)	PPS
		1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST							
90.00	Capital-related cost	373,535	17,029,416	0.021935	723,927	15,879	90.00
91.00	Nursing School cost	0	17,029,416	0.000000	723,927	0	91.00
92.00	Allied health cost	0	17,029,416	0.000000	723,927	0	92.00
93.00	All other Medical Education	0	17,029,416	0.000000	723,927	0	93.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 140300	Period: From 12/01/2011 To 11/30/2012	Worksheet D-3 Date/Time Prepared: 4/29/2013 11:36 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		698,714		30.00
31.00	03100 INTENSIVE CARE UNIT		0		31.00
41.00	04100 SUBPROVIDER - IRF		0		41.00
42.00	04200 SUBPROVIDER		0		42.00
43.00	04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0.456366	49,242	22,472	50.00
51.00	05100 RECOVERY ROOM	0.000000	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53.00	05300 ANESTHESIOLOGY	0.222542	14,048	3,126	53.00
54.00	05400 RADIOLOGY-DIAGNOSTIC	1.194602	177,388	211,908	54.00
56.00	05600 RADIOISOTOPE	0.121751	109,787	13,367	56.00
57.00	05700 CT SCAN	0.000000	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	0	0	58.00
59.00	05900 CARDIAC CATHETERIZATION	0.000000	0	0	59.00
60.00	06000 LABORATORY	0.501454	225,713	113,185	60.00
60.01	06001 BLOOD LABORATORY	0.000000	0	0	60.01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	2.795502	3,008	8,409	62.00
65.00	06500 RESPIRATORY THERAPY	0.000000	0	0	65.00
66.00	06600 PHYSICAL THERAPY	0.895243	3,588	3,212	66.00
67.00	06700 OCCUPATIONAL THERAPY	0.255756	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0.000000	0	0	68.00
69.00	06900 ELECTROCARDIOLOGY	0.727481	71,284	51,858	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.922246	495,645	457,107	73.00
74.00	07400 RENAL DIALYSIS	0.000000	0	0	74.00
OUTPATIENT SERVICE COST CENTERS					
88.00	08800 RURAL HEALTH CLINIC	0.000000		0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89.00
90.00	09000 CLINIC	0.948076	611	579	90.00
91.00	09100 EMERGENCY	0.860248	77,568	66,728	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.916071	0	0	92.00
200.00	Total (sum of lines 50-94 and 96-98)		1,227,882	951,951	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (line 61)		0	0	201.00
202.00	Net Charges (line 200 minus line 201)		1,227,882		202.00

CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 140300	Period: From 12/01/2011 To 11/30/2012	Worksheet E Part A Date/Time Prepared: 4/29/2013 11:36 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		884,765	1.00
2.00	Outlier payments for discharges. (see instructions)		0	2.00
2.01	Outlier reconciliation amount		0	2.01
3.00	Managed Care Simulated Payments		0	3.00
4.00	Bed days available divided by number of days in the cost reporting period (see instructions)		108.25	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)		11.59	5.00
6.00	FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)		0.00	6.00
7.00	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1)		0.00	7.00
7.01	ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions.		0.00	7.01
8.00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv) and Vol. 64 Federal Register, May 12, 1998, page 26340 and Vol. 67 Federal Register, page 50069, August 1, 2002.		0.00	8.00
8.01	The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.		0.00	8.01
8.02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)		0.00	8.02
9.00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8.01 and 8.02) (see instructions)		11.59	9.00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		8.77	10.00
11.00	FTE count for residents in dental and podiatric programs.		0.00	11.00
12.00	Current year allowable FTE (see instructions)		8.77	12.00
13.00	Total allowable FTE count for the prior year.		8.28	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.		11.59	14.00
15.00	Sum of lines 12 through 14 divided by 3.		9.55	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		9.55	18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).		0.088222	19.00
20.00	Prior year resident to bed ratio (see instructions)		0.097076	20.00
21.00	Enter the lesser of lines 19 or 20 (see instructions)		0.088222	21.00
22.00	IME payment adjustment (see instructions)		41,607	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)		0.00	24.00
25.00	If the amount on line 24 is greater than 0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25.00
26.00	Resident to bed ratio (divide line 25 by line 4)		0.000000	26.00
27.00	IME payments adjustment. (see instructions)		0.000000	27.00
28.00	IME Adjustment (see instructions)		0	28.00
29.00	Total IME payment (sum of lines 22 and 28)		41,607	29.00
Disproportionate Share Adjustment				
30.00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		15.26	30.00
31.00	Percentage of Medicaid patient days to total days reported on Worksheet S-2, Part I, line 24. (see instructions)		37.99	31.00
32.00	Sum of lines 30 and 31		53.25	32.00
33.00	Allowable disproportionate share percentage (see instructions)		33.15	33.00
34.00	Disproportionate share adjustment (see instructions)		293,300	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)		1,219,672	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: 140300	Period: From 12/01/2011 To 11/30/2012	Worksheet E Part A Date/Time Prepared: 4/29/2013 11:36 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)		1,219,672	49.00
50.00	Payment for inpatient program capital (from Worksheet L, Parts I, II, as applicable)		91,806	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).		86,493	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)		0	58.00
59.00	Total (sum of amounts on lines 49 through 58)		1,397,971	59.00
60.00	Primary payer payments		0	60.00
61.00	Total amount payable for program beneficiaries (line 59 minus line 60)		1,397,971	61.00
62.00	Deductibles billed to program beneficiaries		197,196	62.00
63.00	Coinsurance billed to program beneficiaries		578	63.00
64.00	Allowable bad debts (see instructions)		29,094	64.00
65.00	Adjusted reimbursable bad debts (see instructions)		20,366	65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		14,884	66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		1,220,563	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	70.93
70.94	Hospital readmissions reduction adjustment (see instructions)		-1,134	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)		1,219,424	71.00
72.00	Interim payments		1,274,841	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)		-55,417	74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-II, section 115.2		0	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: 140300	Period: From 12/01/2011 To 11/30/2012	Worksheet E Part B Date/Time Prepared: 4/29/2013 11:36 am
		Title XVIII	Hospital	PPS
		1.00		
PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)		0	1.00
2.00	Medical and other services reimbursed under OPPS (see instructions)		2,355,311	2.00
3.00	PPS payments		859,992	3.00
4.00	Outlier payment (see instructions)		226,901	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		0	9.00
10.00	Organ acquisitions		0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)		0	11.00
COMPUTATION OF LESSER OF COST OR CHARGES				
Reasonable charges				
12.00	Ancillary service charges		0	12.00
13.00	Organ acquisition charges (from Worksheet D-4, Part III, line 69, col. 4)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13)		0	14.00
Customary charges				
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis		0	15.00
16.00	Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e)		0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)		0.000000	17.00
18.00	Total customary charges (see instructions)		0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)		0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)		0	20.00
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)		0	21.00
22.00	Interns and residents (see instructions)		0	22.00
23.00	Cost of teaching physicians (see instructions, 42 CFR 415.160 and CMS Pub. 15-1, section 2148)		0	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)		1,086,893	24.00
COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)		262,643	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)		0	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)		824,250	27.00
28.00	Direct graduate medical education payments (from Worksheet E-4, line 50)		61,534	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)		885,784	30.00
31.00	Primary payer payments		0	31.00
32.00	Subtotal (line 30 minus line 31)		885,784	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)		15,523	34.00
35.00	Adjusted reimbursable bad debts (see instructions)		10,866	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		6,359	36.00
37.00	Subtotal (sum of lines 32, 33, and 34 or 35) (line 35 hospital and subprovider only)		896,650	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)		896,650	40.00
41.00	Interim payments		897,213	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)		-563	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: 140300	Period: From 12/01/2011 To 11/30/2012	Worksheet E Part B Date/Time Prepared: 4/29/2013 11:36 am
	Title XVIII	Hospital	PPS
			Overrides
			1.00
WORKSHEET OVERRIDE VALUES			
112.00	Override of Ancillary service charges (line 12)		0112.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Provider CCN: 140300

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

Worksheet E-1
Part I
Date/Time Prepared:
4/29/2013 11:36 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		1,336,535		885,591	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	10/23/2012	138	10/23/2012	1,623	3.01	
3.02			0	07/13/2012	9,999	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	61,832		0	3.50	
3.51			0		0	3.51	
3.52			0		0	3.52	
3.53			0		0	3.53	
3.54			0		0	3.54	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		-61,694		11,622	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)		1,274,841		897,213	4.00	
TO BE COMPLETED BY CONTRACTOR							
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00	
Program to Provider							
5.01	TENTATIVE TO PROVIDER		0		0	5.01	
5.02			0		0	5.02	
5.03			0		0	5.03	
Provider to Program							
5.50	TENTATIVE TO PROGRAM		0		0	5.50	
5.51			0		0	5.51	
5.52			0		0	5.52	
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.99	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00	
6.01	SETTLEMENT TO PROVIDER		0		0	6.01	
6.02	SETTLEMENT TO PROGRAM		55,417		563	6.02	
7.00	Total Medicare program liability (see instructions)		1,219,424		896,650	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: 140300

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

Worksheet E-1
Part II
Date/Time Prepared:
4/29/2013 11:36 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			1,657 1.00
2.00	Medicare days from Wkst S-3, Part I, column 6 sum of lines 1, 8-12			896 2.00
3.00	Medicare HMO days from Wkst S-3, Part I, column 6, line 2			70 3.00
4.00	Total inpatient days from S-3, Part I column 8 sum of lines 1, 8-12			6,194 4.00
5.00	Total hospital charges from Wkst C, Part I, column 8 line 200			81,087,194 5.00
6.00	Total hospital charity care charges from Wkst S-10, column 3 line 20			23,527,006 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)			461,711 8.00
INPATIENT HOSPITAL SERVICES UNDER PPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			701,832 30.00
31.00	Other Adjustment (specify)			0 31.00
32.00	Balance due provider (line 8 minus line 30 and line 31)			-240,121 32.00
				Overrides
				1.00
CONTRACTOR OVERRIDES				
108.00	Override of HIT payment			0 108.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 140300	Period: From 12/01/2011 To 11/30/2012	Worksheet E-4 Date/Time Prepared: 4/29/2013 11:36 am	
		Title XVII	Hospital	PPS	
				1.00	
COMPUTATION OF TOTAL DIRECT GME AMOUNT					
1.00	Unweighted resident FTE count for allopathic and osteopathic programs for cost reporting periods ending on or before December 31, 1996.			11.59	1.00
2.00	Unweighted FTE resident cap add-on for new programs per 42 CFR 413.79(e)(1) (see instructions)			0.00	2.00
3.00	Amount of reduction to Direct GME cap under section 422 of MMA			0.00	3.00
3.01	Direct GME cap reduction amount under ACA §5503 in accordance with CFR §413.79 (m). (see instructions for cost reporting periods straddling 7/1/2011)			0.00	3.01
4.00	Adjustment (plus or minus) to the FTE cap for allopathic and osteopathic programs due to a Medicare GME affiliation agreement (42 CFR §413.75(b) and § 413.79 (f))			0.00	4.00
4.01	ACA Section 5503 increase to the Direct GME FTE Cap (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.01
4.02	ACA Section 5506 number of additional direct GME FTE cap slots (see instructions for cost reporting periods straddling 7/1/2011)			0.00	4.02
5.00	FTE adjusted cap (line 1 plus line 2 minus line 3 and 3.01 plus or minus line 4 plus line 4.01 plus line 4.02 plus applicable subscripts)			11.59	5.00
6.00	Unweighted resident FTE count for allopathic and osteopathic programs for the current year from your records (see instructions)			8.77	6.00
7.00	Enter the lesser of line 5 or line 6			8.77	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.	2.29	3.86	6.15	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.	2.29	3.86	6.15	9.00
10.00	Weighted dental and podiatric resident FTE count for the current year		0.00		10.00
11.00	Total weighted FTE count	2.29	3.86		11.00
12.00	Total weighted resident FTE count for the prior cost reporting year (see instructions)	7.90	0.00		12.00
13.00	Total weighted resident FTE count for the penultimate cost reporting year (see instructions)	11.42	0.12		13.00
14.00	Rolling average FTE count (sum of lines 11 through 13 divided by 3).	7.20	1.33		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	7.20	1.33		17.00
18.00	Per resident amount	114,344.12	102,027.25		18.00
19.00	Approved amount for resident costs	823,278	135,696	958,974	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)			0.00	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)			958,974	25.00
		Inpatient Part A	Managed care		
		1.00	2.00	3.00	
COMPUTATION OF PROGRAM PATIENT LOAD					
26.00	Inpatient Days	896	70		26.00
27.00	Total Inpatient Days (see instructions)	6,194	6,194		27.00
28.00	Ratio of inpatient days to total inpatient days	0.144656	0.011301		28.00
29.00	Program direct GME amount	138,721	10,837		29.00
30.00	Reduction for direct GME payments for Medicare managed care		1,531		30.00
31.00	Net Program direct GME amount			148,027	31.00

DIRECT GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT MEDICAL EDUCATION COSTS		Provider CCN: 140300	Period: From 12/01/2011 To 11/30/2012	Worksheet E-4 Date/Time Prepared: 4/29/2013 11:36 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)		0	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)		3,310,635	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)		3,310,635	41.00
Part B Reasonable Cost				
42.00	Reasonable cost (see instructions)		2,355,311	42.00
43.00	Primary payer payments (see instructions)		0	43.00
44.00	Total Part B reasonable cost (line 42 minus line 43)		2,355,311	44.00
45.00	Total reasonable cost (sum of lines 41 and 44)		5,665,946	45.00
46.00	Ratio of Part A reasonable cost to total reasonable cost (line 41 ÷ line 45)		0.584304	46.00
47.00	Ratio of Part B reasonable cost to total reasonable cost (line 44 ÷ line 45)		0.415696	47.00
ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PART B				
48.00	Total program GME payment (line 31)		148,027	48.00
49.00	Part A Medicare GME payment (line 46 x 48) (Title XVIII only) (see instructions)		86,493	49.00
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only) (see instructions)		61,534	50.00

BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column only) Provider CCN: 140300 Period: From 12/01/2011 To 11/30/2012 Worksheet G
 Date/Time Prepared: 4/29/2013 11:36 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	123,194,828	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	13,868,706	0	0	0	4.00
5.00	Other receivable	32,750,779	0	0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-8,980,380	0	0	0	6.00
7.00	Inventory	278,757	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)	161,112,690	0	0	0	11.00
FIXED ASSETS						
12.00	Land	0	0	0	0	12.00
13.00	Land improvements	0	0	0	0	13.00
14.00	Accumulated depreciation	0	0	0	0	14.00
15.00	Buildings	47,100,282	0	0	0	15.00
16.00	Accumulated depreciation	-27,954,964	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	20,950	0	0	0	19.00
20.00	Accumulated depreciation	-20,950	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	12,717,629	0	0	0	23.00
24.00	Accumulated depreciation	-8,675,463	0	0	0	24.00
25.00	Minor equipment depreciable	0	0	0	0	25.00
26.00	Accumulated depreciation	-1,152,614	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)	22,034,870	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)	183,147,560	0	0	0	36.00
CURRENT LIABILITIES						
37.00	Accounts payable	51,733,839	0	0	0	37.00
38.00	Salaries, wages, and fees payable	4,428,824	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	0	0	0	0	41.00
42.00	Accelerated payments	0	0	0	0	42.00
43.00	Due to other funds	0	0	0	0	43.00
44.00	Other current liabilities	69,280	0	0	0	44.00
45.00	Total current liabilities (sum of lines 37 thru 44)	56,231,943	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	1,571,111	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	1,571,111	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	57,803,054	0	0	0	51.00
CAPITAL ACCOUNTS						
52.00	General fund balance	125,344,506				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)	125,344,506	0	0	0	59.00
60.00	Total liabilities and fund balances (sum of lines 51 and 59)	183,147,560	0	0	0	60.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 140300

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

Worksheet G-1

Date/Time Prepared:
4/29/2013 11:36 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		114,261,339		0	1.00
2.00	Net income (loss) (From Wkst. G-3, line 29)		9,976,535			2.00
3.00	Total (sum of line 1 and line 2)		124,237,874		0	3.00
4.00	WORKING CAPITAL TRANSFER	419,605		0		4.00
5.00	CAPITAL TRANSFERS	687,027		0		5.00
6.00		0		0		6.00
7.00		0		0		7.00
8.00		0		0		8.00
9.00		0		0		9.00
10.00	Total additions (sum of line 4-9)		1,106,632		0	10.00
11.00	Subtotal (line 3 plus line 10)		125,344,506		0	11.00
12.00	Deductions (debit adjustments) (specify)	0		0		12.00
13.00		0		0		13.00
14.00		0		0		14.00
15.00		0		0		15.00
16.00		0		0		16.00
17.00		0		0		17.00
18.00	Total deductions (sum of lines 12-17)		0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		125,344,506		0	19.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 140300

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

Worksheet G-1

Date/Time Prepared:
4/29/2013 11:36 am

	Endowment Fund	Plant Fund			
		6.00	7.00		
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	WORKING CAPITAL TRANSFER		0		4.00
5.00	CAPITAL TRANSFERS		0		5.00
6.00			0		6.00
7.00			0		7.00
8.00			0		8.00
9.00			0		9.00
10.00	Total additions (sum of line 4-9)	0		0	10.00
11.00	Subtotal (line 3 plus line 10)	0		0	11.00
12.00	Deductions (debit adjustments) (specify)		0		12.00
13.00			0		13.00
14.00			0		14.00
15.00			0		15.00
16.00			0		16.00
17.00			0		17.00
18.00	Total deductions (sum of lines 12-17)	0		0	18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0		0	19.00

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

Provider CCN: 140300

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

Worksheet G-2
Parts I & II
Date/Time Prepared:
4/29/2013 11:36 am

Cost Center Description		Inpatient	Outpatient	Total	
		1.00	2.00	3.00	
PART I - PATIENT REVENUES					
General Inpatient Routine Services					
1.00	Hospital	5,819,408		5,819,408	1.00
2.00	SUBPROVIDER - IPF				2.00
3.00	SUBPROVIDER - IRF	0		0	3.00
4.00	SUBPROVIDER	0		0	4.00
5.00	Swing bed - SNF	0		0	5.00
6.00	Swing bed - NF	0		0	6.00
7.00	SKILLED NURSING FACILITY				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)	5,819,408		5,819,408	10.00
Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT	0		0	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines 11-15)	0		0	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)	5,819,408		5,819,408	17.00
18.00	Ancillary services	11,229,767	41,643,315	52,873,082	18.00
19.00	Outpatient services	1,208,763	21,185,941	22,394,704	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
24.10	CORF	0	0	0	24.10
25.00	AMBULATORY SURGICAL CENTER (D.P.)				25.00
26.00	HOSPICE				26.00
27.00	OTHER (SPECIFY)	0	0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst. G-3, line 1)	18,257,938	62,829,256	81,087,194	28.00
PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)		61,149,961		29.00
30.00	ADD (SPECIFY)	0			30.00
31.00		0			31.00
32.00		0			32.00
33.00		0			33.00
34.00		0			34.00
35.00		0			35.00
36.00	Total additions (sum of lines 30-35)		0		36.00
37.00	DEDUCT (SPECIFY)	0			37.00
38.00		0			38.00
39.00		0			39.00
40.00		0			40.00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer to Wkst. G-3, line 4)		61,149,961		43.00

STATEMENT OF REVENUES AND EXPENSES

Provider CCN: 140300

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

Worksheet G-3

Date/Time Prepared:
4/29/2013 11:36 am

		1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	81,087,194	1.00
2.00	Less contractual allowances and discounts on patients' accounts	39,749,604	2.00
3.00	Net patient revenues (line 1 minus line 2)	41,337,590	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)	61,149,961	4.00
5.00	Net income from service to patients (line 3 minus line 4)	-19,812,371	5.00
OTHER INCOME			
6.00	Contributions, donations, bequests, etc	0	6.00
7.00	Income from investments	1,722	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	154,818	12.00
13.00	Revenue from laundry and linen service	0	13.00
14.00	Revenue from meals sold to employees and guests	0	14.00
15.00	Revenue from rental of living quarters	0	15.00
16.00	Revenue from sale of medical and surgical supplies to other than patients	0	16.00
17.00	Revenue from sale of drugs to other than patients	244,410	17.00
18.00	Revenue from sale of medical records and abstracts	0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)	0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen	0	20.00
21.00	Rental of vending machines	0	21.00
22.00	Rental of hospital space	0	22.00
23.00	Governmental appropriations	29,387,956	23.00
24.00	OTHER (SPECIFY)	0	24.00
25.00	Total other income (sum of lines 6-24)	29,788,906	25.00
26.00	Total (line 5 plus line 25)	9,976,535	26.00
27.00	OTHER EXPENSES (SPECIFY)	0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)	0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)	9,976,535	29.00

CALCULATION OF CAPITAL PAYMENT		Provider CCN: 140300	Period: From 12/01/2011 To 11/30/2012	Worksheet L Parts I-III Date/Time Prepared: 4/29/2013 11:36 am
		Title XVII	Hospital	PPS
				1.00
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier		71,356	1.00
2.00	Capital DRG outlier payments		0	2.00
3.00	Total inpatient days divided by number of days in the cost reporting period (see instructions)		16.92	3.00
4.00	Number of interns & residents (see instructions)		9.55	4.00
5.00	Indirect medical education percentage (see instructions)		17.27	5.00
6.00	Indirect medical education adjustment (line 1 times line 5)		12,323	6.00
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)		15.26	7.00
8.00	Percentage of Medicaid patient days to total days reported on Worksheet S-3, Part I (see instructions)		37.99	8.00
9.00	Sum of lines 7 and 8		53.25	9.00
10.00	Allowable disproportionate share percentage (see instructions)		11.39	10.00
11.00	Disproportionate share adjustment (line 1 times line 10)		8,127	11.00
12.00	Total prospective capital payments (sum of lines 1-2, 6, and 11)		91,806	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